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ABSTRACT

The development of competencies for a rehabilitation counselor education program can enable the rehabilitation counselor to assist clients effectively. Survey results of members of the National Rehabilitation Counseling Association (NRCA) agreed that 70% of the Michigan Competencies for Rehabilitation Counselors were a legitimate part of the rehabilitation counselor's job. Slightly fewer than 30% were not considered to be a part of the rehabilitation counselor's job. Substantial agreement exists that the proposed competencies are relevant in several categories: counseling process, case management, human behavior, client assessment, medical aspects of disability and job analysis/placement/restructuring. Research utilization and management/supervision competencies were consistently perceived as irrelevant to the function of rehabilitation counselors. Although participants felt that some graduate education/training was required for the satisfactory achievement and demonstration of the competencies, most agreed that about 15 hours of graduate study is sufficient to achieve proficiency in 66% of the competencies. Different expectations exist between rehabilitation educators and personnel as to the division of labor and educational requirements in state-federal rehabilitation programs. (BN)

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MICHIGAN STUDIES IN REHABILITATION

Series 1, Monograph III

General Editors:
Ralph M. Crystal
Juliet V. Miller

Competency Evaluation in Rehabilitation (CEIR): Rehabilitation Counseling Competencies

By

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TABLE OF CONTENTS

CHAPTER PAGE

I INTRODUCTION. 1

II REVIEW OF THE LITERATURE AND RELEVANT STUDIES. 7

III METHODS AND PROCEDURES. 23

IV RESULTS 27

General Findings 27

Specific Findings Related to

Research Questions. 33

Research Question 1 36

Research Question 2 45

Research Question 3 49

Research Question 4 52

Research Question 5 54

V DISCUSSION. 56

Extent of Agreement with Competencies. 56

Extent of Disagreement with Competencies. 57

Satisfaction with Competencies. 58

Utilization of Competencies with Clients. 58

Education/Training Requirements. 59

Appropriateness of the Competencies for Other Rehabilitation Professionals. . 59

Relationship to Previous Research. 60

4

TABLE OF CONTENTS

CHAPTER PAGE

VI SUMMARY. 65

BIBLIOGRAPHY. 69

APPENDIX A. 71

APPENDIX B. 119

APPENDIX C. 123

APPENDIX D. 126

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7

Competency Evaluation in Rehabilitation (CEIR): Rehabilitation Counseling Competencies

CHAPTER I

INTRODUCTION

With the passage of the Vocational Rehabilitation Act of 1954 (Public Law 83--565), rehabilitation counselor training programs proliferated. This act authorized the Rehabilitation Services Administration (RSA) to encourage and support the development of programs in universities which would provide for the graduate training of rehabilitation counselors.

The basic rationale behind the graduate training programs for rehabilitation counselors has been the need for specialized professional personnel in vocational rehabilitation (VR) who are able to provide high quality services to clients. Professional associations in the field have clearly articulated this rationale.

The policy of the American Rehabilitation Counseling Association (ARCA) asserted that the ultimate objective of graduate training programs was to assure that clients receive high quality counseling services. The National Rehabilitation Association (NRA) stated in its policy on federal support of training of the rehabilitation profession,

> Rehabilitation professions are, in the main, new professions, i.e., rehabilitation counseling, vocational evaluation and work adjustment, rehabilitation facility administration, rehabilitation medicine. The special training needed for such individuals is not available

> in schools providing training for the more established professions such as teaching, social work, psychology, medicine, etc. It is unrealistic to think that rehabilitation agencies can secure the personnel they need from these established schools. In addition, a most valuable part of the use of federal funds by the colleges and universities has been to facilitate the recruitment of individuals into fields of services to handicapped individuals. (McFarlane, Hillis, Johnson, & Meadow, 1973, pp. 66-67).

If the need for graduate training programs for rehabilitation counselors is universally understood, disparities nonetheless exist concerning the makeup of the core curriculum of the training program. Professional organizations have published a series of standards relating to the content of rehabilitation counselor education and the job of the rehabilitation counselor. The development of rehabilitation counselor education training programs has been based upon these standards, but their terminology is too broad and generalized to indicate what specific skills and knowledge are needed to train competent rehabilitation counselors.

Consequently, it is the responsibility of rehabilitation counselor educators to incorporate into the training program their projection of the future development and advancement of the profession, as well as the actual functions of the rehabilitation counselor.

The nature of the functions of the rehabilitation counselor is changing as professionalization progresses and as societal needs change. Sinick (1973) noted that client populations and target groups can be expected to shift from the early emphasis on the physically disabled to include the emotionally disturbed, the mentally retarded, the disadvantaged, public offenders and juvenile delinquents, drug and alcohol abusers, and groups of the physically disabled not previously served. New client needs will certainly be accompanied by corresponding changes in rehabilitation counselor settings, rehabilitation counselors' roles, and rehabilitation counselors' preparation.

The complexity of the rehabilitation counselor's function, as well as the lack of consensus among professionals with regard to rehabilitation counselor roles, is suggested by the wide range of tasks included in such studies as Muthard and Salomone (1969), Tripp (1975), and Wright and Fraser (1975), and in the variety of methods adopted in developing rehabilitation counselor task banks.

The study by Muthard and Salomone suggests that a discrepancy exists between rehabilitation counselors' actual role and the perceived/expected role of the rehabilitation counselors and agency heads. Increased cooperation and understanding between agency and university are recommended by Muthard and Salomone and Tripp.

Based on role complexity, role conflict, and disagreement on the actual functions of rehabilitation counselors in the field, it seems appropriate that an investigation be conducted on rehabilitation counselors' competencies which are reflective of both rehabilitation counseling practitioners' and rehabilitation counselor educators' perceptions of the competencies needed by rehabilitation counselors.

Statement of the Problem

The purpose of this study was to determine the relevance of a group of proposed competencies for a master's degree program in rehabilitation counseling as assessed by employed rehabilitation professionals with experience in rehabilitation counseling.

The relationship between the university rehabilitation counselor education program and the role of the professional in actual practice has been shown to be of concern to rehabilitation counselor educators, practitioners, administrators of rehabilitation programs, and consumers of rehabilitation services. This project addressed the problem of the development of competencies for a rehabilitation counselor education program which will enable the rehabilitation counselor to assist clients in achieving goals, specific competencies, and objectives. The basic objective of the project was to identify the competencies required of rehabilitation counselors to function effectively in rehabilitation settings. (Data gathered from this study are also part of the end results of planning efforts for the rehabilitation counseling program at The University of Michigan).

Significance of the Problem

The significance of this investigation is the need to establish a relevant rehabilitation counseling curriculum which will develop competencies enabling rehabilitation counseling trainees to function effectively in bringing about desired changes in persons with severe disabilities. Further, the investigation is an attempt to delineate the specific areas of agreement and disagreement on the competencies perceived to be needed by rehabilitation counselors as the ground for appropriate curriculum changes.

Significance to Client

Evaluation of the effectiveness of rehabilitation counseling is based upon assessment of the desired competencies and outcomes in clients. It seems crucial to identify the competencies needed by rehabilitation counselors and to link these to the competencies and outcomes which are to be brought about in clients. While this investigation is chiefly concerned with the judgment of experts regarding the desirability of certain competencies, a groundwork is also being laid for (a) subsequent validation of the competencies, and (b) the establishment of the linkages between the competencies possessed by rehabilitation counselors and the outcomes and competencies of clients receiving rehabilitation.

Significance to Counselors and Rehabilitation Organizations

Where previous studies have focused on what the rehabilitation counselor does in practice, this study focuses on what the counselor needs to know and is able to perform to be effective. Since ultimate concern pertains to the role of rehabilitation counselor education in meeting client needs, these competencies may not relate directly to the current job tasks of rehabilitation counselors.

Research Questions

Several issues are addressed by the investigation in the form of five major research questions:

1. To what extent do rehabilitation personnel with experience in rehabilitation counseling agree that the proposed competencies are a part of or should be a part of the rehabilitation counselor's job?
2. What degree of satisfaction is derived from having to demonstrate the competencies with clients?
3. How frequently do rehabilitation personnel with experience in rehabilitation counseling find that the proposed competencies are needed with the range of clients in a caseload?
4. What level of training is perceived as being needed by experienced rehabilitaion counselors to achieve proficiency in the competency areas?
5. To what extent do rehabilitation counselors feel that the competencies are appropriate for other rehabilitation personnel?

CHAPTER II

REVIEW OF THE LITERATURE AND RELEVANT STUDIES

Professional Standards

The proceedings of the Charlottesville Workshop held at the University of Virginia in 1955 were edited by Hall and Warren (1956). The following content areas essential to the professional education of the rehabilitation counselor were outlined: An Introduction to Rehabilitation; Legislative Aspects of Rehabilitation; Human Development and Behavior; Medical Aspects of Rehabilitation; Cultural and Psychological Evaluation; Counseling Techniques; Occupational and Educational Information; Community Resources; Placement and Follow-up; Research and Statistics; and Supervised Experience.

A rather comprehensive list--these areas remain the crux of most graduate rehabilitation counselor training programs. Although this list offers a general guide for curriculum development, the lack of specificity in skills and knowledge needed under each subject area does not shed light on the current confusion concerning what competencies rehabilitation counselors need to develop through their education and training to assist clients in achieving desirable competencies.

In 1962, the National Rehabilitation Counseling Association (NRCA) established professional standards: The Rehabilitation Counselor--What He Is and Does.

The standards describe the rehabilitation counselor as follows:

> 1. He is a person capable of, and continuously applying himself to, studying and gaining understanding of behaviors of individuals and society as they interact from the impact of disability.
>
> 2. He is a person capable of practicing skills that use the client-rehabilitation counselor relationship to help the client develop and realize suitable goals.
>
> 3. He is a person whose proficiency will demand his knowledge and skills in the areas of economics, business administration, labor market information, job analysis (from the view of physical, mental, and emotional requirements), labor management relations, legal and regulatory requirements for employment, and vocational counseling--in addition to medical information and community organization.
>
> 4. He is a person whose knowledge, in addition to that of behavior dynamics, must include knowledge in depth of the world of work, and his skills in applying it to meet the needs of the disabled must be so effective that he can claim this sphere of function as his and that of other professions (NRCA, 1961, p. 17).

In these criteria statements the NRCA emphasized the importance of professionalism, the in-depth knowledge of the world of work, and being able to apply it effectively to meet the needs of the disabled. Otherwise, the criteria do not differ significantly from those generated at the Charlottesville Workshop in 1955.

In 1963, the Joint Liaison Committee published the report, Guidelines for Supervised Clinical Practice, listing the following courses/areas as prerequisites to supervised clinical practice: Counseling Principles and Techniques; Occupational

Information; Principles and Techniques of Assessment; Dynamics of Human Behavior; Community Organization; Survey of Vocational Rehabilitation; Statistics; Social Psychology; Psycho-social Aspects of Disability; Medical Information; Practicum in Evaluating and Counseling People with Disabling Conditions; Psychology of the Handicapped; Psychology of Personality; and Research Methods.

This report adds no new categories to the 1955 Charlottesville Workshop; however, more attention appears to have been given to psycho-social-medical aspects of the handicapped.

In 1964, the American Personnel Guidance Association Committee on Professional Preparation and Standards listed the following recommendations for counselor preparation:

1. Counselor education should be designed to achieve carefully formulated goals based on the philosophy which reflects the highest level of professional knowledge and social concepts.

2. The counselor education staff should be concerned with the task of continually evaluating the program and searching for more adequate methods of counselor preparation. The curriculum should be sufficiently flexible and dynamic to permit revisions and adjustment as required by increasing professional knowledge or by changes in the professional knowledge or by change in the professional responsibilities of counselors.

3. The curriculum of the counselor education program should assure that essential content and experiences are included in each candidate's program, should provide increasingly for integration of learning, and should avoid duplication of content. Each candidate's program, of course, should constitute a planned sequence spiraling toward progressively more advanced work. Programs should recognize individual differences among counselor candidates (their ability, goals, educational background, and experience), and should challenge each person individually.

4. Counselor education should provide experiences which are planned to contribute to the counselor candidate's growth in self-understanding.

5. The counselor education program should assure that each counselor candidate has a background (undergraduate or graduate) in the humanities and in the social, behavioral, and biological sciences that helps him understand individuals, their behavior and adjustments; the nature of the environment and its impact on the individual, including the forces that affect his personal and vocational life; and the counselor's role in a changing culture.

6. There should be provision to promote the integration of studies in related disciplines with the professional studies in counseling in such a manner that these related studies will make meaningful contributions to the competence of the counselor.

7. The program should provide for such specialized study related to the setting in which the counselor will work as is needed to enable him to function effectively within that employment environment and to perform such duties in addition to counseling as may be an appropriate part of his professional role.

8. There should be a year-round program of counselor preparation that makes possible full-time graduate study. There also should be opportunities for additional continuing education of practicing counselors.

9. A program of counselor preparation which would meet the principles listed above as well as provide the professional studies described below would consist of a minimum of two years of graduate study, a substantial portion of which should be in full-time graduate study (American Personnel and Guidance Association, 1964, pp. 535-541).

These recommendations were seemingly related more to program management than to curriculum content. The recommendations advocated flexibility and individuality in the program. In the area related to the development of counselor competencies, it was recommended that studies in related disciplines be integrated with professional studies in counseling.

Based on the assumption that there is much in common among counselors working in non-school settings--state employment services, rehabilitation centers, sheltered workshops--the American Rehabilitation Counseling Association (ARCA) and National Vocational Guidance Association (NVGA) developed a single set of standards.

A preliminary report of the ARCA-NVGA standards committee specified the following regarding counselor preparation:

A. Goals and Objectives:

> The objective of professional education is not training for a specific job or position but for general competency which will qualify the individual for entrance in the ongoing competency in professional activities. Education would be process oriented and, as such, it never ends. Therefore, a professional curriculum is concerned with inculcating methods and habits of continuous learning in the promoting of professional attitudes and identification, and a critical, questioning and exploratory attitude. Knowledge and skills are requisite foundations, but not sufficient for the assumption of professional responsibilities.
>
> An essential aspect of education for the counseling profession is the inculcation of a belief in the respect for the rights, abilities, and desires of others consistent with the democratic philosophy which pervades our society.

B. Level and Nature of the Curriculum

> An adequate curriculum of counselor preparation should meet the following requirements:
>
> 1. Counselor preparation is graduate level work. Paramount is the development of an understanding and acceptance of the philosophy, psychological principles, and theory that are the foundations of counseling. Techniques and skills are operations deduced from this broader base.
> 2. Two years of study, a substantial part of which is on a full-time basis, is necessary for adequate preparation in counseling.

3. While the program may be adaptive to differing backgrounds and individual differences among students, there is a well-defined and patterned sequence of courses fundamental to preparing a professional counselor.

4. The curriculum should include the following elements:

   (a) The foundations of human behavior and methods of behavior change

   (b) Social-cultural-economic factors influencing individuals and groups

   (c) Professional studies in counseling

      (1) philosophy and fundamental assumptions in counseling services

      (2) counseling theory and practice

      (3) group approach to counseling

      (4) supervised experience in counseling

   (d) Vocational psychology, or the psychology of vocational development and the social-environmental information necessary for vocational choice

   (e) Psychological appraisal by means of tests and other methods of evaluation and measurement, including the requisite statistics

   (f) Specific preparation for the setting in which the counselor will work. This will include material related to the agency or agencies and their programs, the community setting and its resources, needs and problems. For the rehabilitation counselor this will include the physical (medical) and psychological aspects of disability as well as an understanding of the nature and organization of rehabilitation services to the individual. Counselors preparing for employment in community agencies dealing with the societally underprivileged or handicapped and the occupationally displaced adult will need special preparation for understanding and working with these clients, including social provisions for unemployment, retraining, and placement.

(g) While there may be no specific courses dealing with the general personal and professional development of the counselor candidate, there should be opportunity, both formal and informal, for the candidate to

(1) develop in self-understanding, including opportunity for personal counseling

(2) understand, observe, or participate in research studies or activities

(3) engage in independent or advanced study in areas of special interest

(4) integrate the various aspects of the curriculum including theory and practice (McGowan & Porter, 1967, pp. 161-162).

Although the basic emphasis on the content of the curriculum is generally the same as the other recommendations for counselor preparation, the ARCA-NVGA standards appeared to be more specific in the areas of the counseling, personal, and professional development of counselor trainees. The Standards Committee considered knowledge and skills as requisite foundation, but as insufficient for the assumption of professional responsibilities. It was felt that the counselor training program should also promote professional attitudes; professional identification; and a critical, questioning and exploratory attitude.

Rehabilitation Counselors' Role, Functions, Job Tasks

Muthard and Salomone's (1969) research is regarded as the comprehensive study on rehabilitation counselors' roles and functions. The authors' purpose was to identify the functions actually performed by rehabilitation counselors in various settings, and to determine the perceptions of counselors, supervisors, administrators, counselor educators and other professional rehabilitation workers of the current role and the desirable role for the rehabilitation counselor. A sample of 378 volunteer rehabilitation counselors, nationwide, were stratified by type of the agency, training level, experience level, and geographic area. One of the major instruments used was the task inventory developed by Morsh, Madden, and Christal (1961) of the United States Air Force Personnel Research Laboratory.

A total of 119 items in the task inventory were grouped under 7 categories. The authors explain that several sources were used for the preliminary development of the task inventory. One such source was job descriptions solicited from over 250 agencies in the United States: these agencies included not only the vocational rehabilitation agency of each state but many types of private, federal, and other state facilities. In addition, former students of the principal investigator were asked to outline in detail their current job tasks and duties; and the research associate for the project, a former rehabilitation counselor, also listed the tasks involved in his work experiences in a private rehabilitation center. The statements were then combined and modified. A test-retest reliability was conducted in order to revise items. The sources of the study's task inventory items were very comprehensive.

In a similar investigation undertaken by Tripp (1975), the criteria adapted to establish a task bank on core competencies for professional rehabilitation counseling were different. The purpose of this study was to identify the core knowledge and skill-based competencies which would best prepare professional rehabilitation counselors for practice specifically in state divisions of vocational rehabilitation agencies in HEW Region VIII. A non-random sample was obtained of 355 people (243 vocational rehabilitation counselors, 44 vocational rehabilitation supervisors, and 68 vocational rehabilitation administrators) who were employed by the State Division of Vocational Rehabilitation in Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. His survey questionnaire consisted of 11 major competency categories and 128 subject items. A major reference used in developing his questionnaire was the curriculum catalogues of graduate rehabilitation counselor education programs across the United States which were apparently seen as reflective of the biases of rehabilitation counselor educators. In point of fact, due to the discrepancy between the goals of rehabilitation counselor educators and the goals of the agencies (Muthard & Salomone, 1969), rehabilitation counselors may actually perform tasks on the job that are different from tasks learned in graduate school. Thus, using graduate training curriculum catalogues as the source for developing the core competencies of rehabilitation counseling might not be entirely representative of needs in the field. In addition to curriculum catalogues, Tripp, during the stage of item selection and revision, asked the rehabilitation counselors and graduate students at the University of Northern Colorado to make suggestions. Rehabilitation counselors, supervisors, and administrators from the State Division of Vocational Rehabilitation Services in Colorado were also surveyed and asked to make recommendations. The final questionnaire elicited 128 competencies classified under 11 categories.

Scorzelli (1975) conducted a job task analysis to assist the newly formed rehabilitation counseling program at Northeastern University in curriculum development and instructional planning. A sample was obtained of 55 rehabilitation counselors employed in 32 state agencies and 36 facilities in the New England region. The questionnaire used consisted of 87 tasks categorized under 17 general functions. The primary source of item generation was obtained from a thorough review of the literature on the roles and functions of the rehabilitation counselor. No specific procedure in finalizing the functions acquired from previous research was mentioned.

To prepare guidelines for training DVR supervisors to fulfill their manpower utilization responsibilities, Wright and Fraser (1975) at the University of Wisconsin-Regional Rehabilitation Research Institute (UW-RRI) constructed a comprehensive task bank--"Rehabilitation Job Task Inventory"--consisting of 294 task statements under 12 main categories. The method used in establishing the task bank was very sophisticated: A functional job analysis procedure (FJA) developed initially by Fine (1973) was adapted to obtain a large pool of task statements. This task bank was expanded by collecting tasks obtained from other sources and methodologies, including the task inventory and critical-incident approaches. Rehabilitation counselor-track job descriptions from every state civil service agency were obtained for additional tasks. This scientifically built task bank focused only on the tasks performed in state DVR agencies.

In summary, from studies of rehabilitation counselor roles and functions just reviewed, two observations can be made.

1. The number of tasks and general categories vary as follows:
    a. Muthard & Salomone (1969)--119 items, 7 categories
    b. Tripp (1975)--128 items, 11 categories
    c. Scorzelli (1975)--87 items, 17 categories
2. The procedure used in identifying rehabilitation counselor tasks varied as follows:
    a. surveyed through questionnaire (Muthard & Salomone, 1969)
    b. used expert panel as information source (Tripp, 1975)
    c. reviewed the literature (Scorzelli, 1975; Wright & Fraser, 1975)
    d. used existing method (Wright & Fraser, 1975)

Complexity of the rehabilitation counselors' roles and the lack of consensus among professionals concerning the actual rehabilitation counselors' functions are the conditions that emerge as a result of these studies.

Rehabilitation Counselors' Role Strain

From the organizational point of view, several forces are at work in determining the counselor's role. Haettenschwiller (1970) in his article titled "Control of the Counselor's Role," indicated that the power of sanction of those counselor role senders--principal, teacher, student, parents, and counselor educator--all possess and exert some influence on the focal person, the counselor. The principal who interacts with the counselor as a supplier, collaborator, consumer, and source of reward is in the position of controlling sanctions while lacking the qualification for professionally prescribing the role. Whereas counselor educators, however, are responsible for communicating the professional demands of the role, they lack the power to establish sanctions for insuring that the performance of the role is in accord with demand. The functional dependence of the counselor on the principal for the accomplishment of certain tasks excludes the counselor from actualizing the sanctioning power of internalized professional norms obtained during professional training under the counselor educator. This is one of the factors which has given rise to the difference between the counselor's ideal and actual role. The role taken in the vocational rehabilitation agency is different from what is projected in the school setting. Furthermore, instead of the school principal, the agency's administrator and supervisor then have a similar type of control over rehabilitation counselors.

This theory concerning rehabilitation counselors' role strain is supported by empirical findings: As a result of Muthard and Salomone's (1969) study, educators estimated that about half of the 40 tasks in the Abbreviated Rehabilitation Counselor Task Inventory should be more vital and salient parts of the counselor's job than counselors report them to be. The study showed, in other words, that other professional rehabilitation worker groups rated the desirable level of importance higher for nearly all tasks than did counselors. Agency heads also seem to think that most rehabilitation counselor tasks should be more intrinsic to the rehabilitation counselor's job than the tasks of agency heads to their jobs. This discrepancy between the rehabilitation counselors' role behaviors and role expectations from rehabilitation counselor educators, other professional rehabilitation worker groups, and agency heads, constitutes the role strain of rehabilitation counselors. In the same study, a discrepancy between the rehabilitation counselor educators' perception and the administrators' and supervisors' perception of the rehabilitation counselors' current role behavior was found to exist. Muthard and Salomone concluded that agency orientation appeared to be substantially different from the university orientation. They felt that it was not an exaggeration to view these differences with considerable alarm and to admonish educators to align their curricula with the real world. It was suggested that educators might need to adjust their expectations and their programs to offer optimal preparation for agency employment. Changes in this direction might ameliorate some of the role strain experienced by counselors, especially the more recently trained. Tripp (1975) suggested that state DVR counselors, supervisors, administrators, and vocational rehabilitation counselor educators in Region VIII need to communicate with one another, so that training needs can be met in the most effective manner.

In view of (a) the lack of specificity in knowledge and skills needed by a competent rehabilitation counselor as reflected in professional standards, (b) the lack of consensus among professionals about rehabilitation counselors' role and functions, and (c) the different perceptions between rehabilitation counselor educators and agency supervisors which produce role strain experienced by the rehabilitation counselors, determining rehabilitation counselors' requisite competencies would appear to be valuable in establishing rehabilitation counselor education programs.

Scorzelli's (1975) job task analysis, which was used as the basis for curriculum and instructional planning in a rehabilitation counseling program, appears to be similar to the current effort at The University of Michigan. The major difference, if any, is that Scorzelli's analysis focuses on job task analysis while the present study focuses on competencies development.

Another rationale for establishing a competency-based program was derived from the criticism that traditional rehabilitation counselor education programs have relied heavily on the teaching of concepts and theories (Anthony, Slowkowski, & Bendix, 1976). Rehabilitation counseling students have traditionally learned--and have been evaluated in--content areas which emphasized vocational development theory, counseling theory, personality theory, and various concepts related to the medical and the psychological aspects of disability. It is suggested that rehabilitation counseling needs to be defined by more than its theoretical expertise. It must be defined also by its mastery of a specific set of skills and knowledge. In order to achieve this goal, Anthony et al. (1976) proposed to set specific, observable goals for some of the traditional rehabilitation courses. Those goals can be used to measure objectively whether the course has changed any of the students' physical, intellectual, and emotional skills.

According to Randolph (1974), competency-based programs refer to those that explicitly define the competencies to be acquired and the assessment criteria. Elfenbein (1972) described three types of standards by which the student is assessed: (a) performance--the student demonstrates required behavior; (b) knowledge--the student demonstrates required cognitive understanding; (c) product--the student demonstrates, through his teaching, changes in the behavior of the pupil. Using the above three criteria for the assessment of a competency-based program, the program can become accountable to students and consumers, allowing students to progress by mastery of the specific competencies rather than by pre-determined time constraints. Brammer and Springer (1971) foresee little improvement within the counseling profession until the traditional college-credit based programs are given up and performance-based training programs initiated.

This present study was motivated by (a) the need for improved understanding between practitioners and educators of the competencies needed by rehabilitation counselors; (b) the need for planning and developing a relevant curriculum; and (c) the need for establishing relevant instructional objectives in a newly established competency-based rehabilitation counselor training program at The University of Michigan.

CHAPTER III

METHODS AND PROCEDURES

Respondents

The respondents were 48 active professionals (17 females and 31 males) in the field of rehabilitation with at least one year of experience as rehabilitation counselors. Participants were members of the National Rehabilitation Counseling Association (NRCA). The majority of the respondents were employed in the State-Federal Vocational Rehabilitation program.

Procedure

A membership list was obtained in May 1975, of persons who were members of NRCA in the state of Michigan. Every fourth name was selected, and a letter was mailed inviting that individual to attend a meeting at The University of Michigan to participate in planning a competency-based rehabilitation counselor education program. Each person was informed that the qualification for participation was based on current employment in rehabilitation and the possession of at least one year of experience as a rehabilitation counselor. Of 200 persons identified as belonging to NRCA, 55 names were selected and mailed letters. Forty-eight persons responded. Travel expenses and a small honorarium were provided.

Instruments

Questionnaire

A questionnaire (Appendix B) was designed primarily for the gathering of demographic data including education, experience in rehabilitation, and other background information. Data were requested from rehabilitation counselors regarding the use of their time.

The Rehabilitation Counselor Competency (Task) Inventory

The Task Inventory technique, developed by Morsh, Madden, and Christal (1961) and modified by Muthard and Salomone (1969), was the primary instrument employed in eliciting perceptions about the proposed competencies for the rehabilitation counseling program.

The competency (task) statement and the six scales used by rehabilitation counselors in responding to the competencies are in Appendix C. Participants were asked to substitute the terms "task" and "competency" as appropriate in responding to the scales.

Michigan Rehabilitation Counseling Competencies

The Michigan Competencies for Rehabilitation Counselors (Harrison & Zawada, 1975) were developed out of the efforts of the Rehabilitation Planning committee. Competency items were generated based on the rehabilitation experience of the authors, the planning committee, and as the result of interviews with employed rehabilitation counselors, supervisors, and administrators in the Michigan Bureau of Rehabilitation.

The planning committee suggested the competencies and assisted in clarification of the language. Several meetings of the Rehabilitation Planning committee resulted in a consensus on 11 competency areas and a total of 90 competency statements.

Data Collection

The Rehabilitation Counselor Competency (Task) Inventory was administered on a Saturday (June 25, 1975) over a 3-hour period. Participants were informed that the purpose of responding to the inventory was to obtain their judgment, in view of their experience as rehabilitation counselors, about the relevance of the rehabilitation counseling competencies for a master's degree rehabilitation counseling curriculum. Following the administration of the inventory, other questions were answered regarding the project's goals.

Data Analysis

Data were analyzed by descriptive and inferential techniques. Means and standard deviation scores were used to describe the assessment of the competencies. T-tests were utilized for significant differences between the demographic characteristics.

Limitations and Assumptions

1. The small number of respondents representing a single geographic location (Michigan) limits the generalizations which may be drawn from the results.
2. Since most of the participants were employed in the state-federal vocational rehabilitation program, caution

is warranted in generalizing from the data to other rehabilitation settings.

3. In responding to the competencies needed to function effectively in the role of rehabilitation counselor, it was assumed that supervisors/administrators would be able to recall accurately their experiences as rehabilitation counselors.

CHAPTER IV

RESULTS

General Findings

The education level of the respondents was primarily master's and post-master's degree (Table 1), with the majority (78%) having specialized in rehabilitation counseling or counseling. (Table 2).

In reflecting upon their own education background, respondents were asked to evaluate eight education courses in terms of the adequacy of each in preparing them as rehabilitation counselors. To assess perceptions of respondents, a Likert-type scale was used with ranges from 1 (superior) through 3 (adequate) to 5 (completely inadequate). Table 3 summarizes the mean rating scores given by the rehabilitation counselors for the adequacy of each course in their rehabilitation counselor preparation.

The lower the mean score, the more adequate the course is perceived to be in preparing the rehabilitation counselor. It seems clear from table 3 that the eight courses evaluated were viewed as only moderately satisfactory. None of the courses were rated "completely inadequate" or "superior." Courses such as psychological assessment, philosophy of rehabilitation, and medical information were considered to have

Table 1

The Academic Degree of the Respondents

Degree	N	%
B.A.	2	4
B.A.+	4	8
M.A.	19	40
M.A.+	21	44
Ph.D.	2	4
TOTAL	48	100

Table 2

The Field of Study of the Respondents

Field	N	%
Rehabilitation Counseling	23	48
Counseling	14	30
Psychology	3	6
Social Work	2	4
Special Education	2	4
Education	2	4
Others	2	4
TOTAL	48	100

Table 3

Mean Ratings of the Adequacy of the Rehabilitation Counselor's Preparation in Selected Educational Courses

Course Title	Mean	SD
1. Rehabilitation Counseling Process	3.19	1.12
2. Philosophy of Rehabilitation	2.80	1.14
3. Psychology of the Disabled	3.02	1.20
4. Placement	3.69	1.29
5. Environmental Information	3.31	.98
6. Community Resources	3.21	1.28
7. Psychological Assessment	2.38	.94
8. Medical Information	2.97	1.24

been slightly more than adequate (mean rating less than 3), and five other courses were considered to have been slightly less than adequate.

Table 4 summarizes previous background and interest perceived as desirable prior to entering the rehabilitation counseling profession.

Achieving a passing score on the State Civil Service Examination has been a prerequisite for being employed as a rehabilitation counselor with the Michigan Bureau of Rehabilitation. Asked whether that examination is an adequate determinant of counselor competency, 40 out of 45 respondents (87%) gave a negative response. Respondents suggested that personal experience and education (29%), probational trial (23%), interview (16%), previous experience (16%), and a revised testing procedure (16%) would be more adequate measures of potential counselor competency than the currently used State Civil Service Examination.

Participants were asked to indicate how they spent their time on the job. Table 5 reflects how that time was distributed on a weekly basis among a number of rehabilitation counselor functions/tasks.

Counseling (22. 09%), report writing (19. 37%), and job placement (12. 18%) occupy most of the time of the rehabilitation counselor. Asked whether they would like any change in time devoted to certain functions/tasks, 31 (76%) indicated that they wanted some changes. Fifteen (36%) wanted to in-

Table 4

Types of Interest and Background Considered Desirable by Rehabilitation Counselors, Prior to Entering the Rehabilitation Counseling Profession

Recommended Interest and Background	N	%
1. Degree	1	2
2. Related working experience	17	38
3. Knowledge in rehabilitation counseling	8	18
4. Skills in rehabilitation counseling	5	12
5. Motivation to help people	7	15
6. Being open-minded	1	2
7. Degree + experience + knowledge in rehabilitation counseling	6	13
TOTAL	45	100

Table 5

Mean Percentage of Vocational Rehabilitation Counselors' Weekly Time Distribution

	Activities	N	Mean (%)	S.D.
1.	Intake Interview	39	9.58	5.49
2.	Counseling	43	22.09	12.31
3.	Job Placement	37	12.18	13.28
4.	Staff Meetings	45	9.93	2.96
5.	Conferences	44	6.32	5.08
6.	Report Writing	45	19.37	13.13
7.	Psychological Testing	12	4.75	5.13
8.	Arranging medical, psychological & Training appointments	35	8.62	7.15
9.	Supervising Clients in Training	37	7.48	6.10
10.	Follow-up of Clients in Job Placement	37	7.27	6.78
11.	Other	23	19.60	17.14

crease time spent counseling: 17 (64%) would have preferred to decrease the time spent on writing reports.

Thirty-four (74%) of the respondents indicated that job placement was a part of their job responsibilities. Counselors reported that they spent about 7 hours per week placing clients in the job market. Eleven (55%) respondents who felt the amount of hours spent on job placement was not adequate wanted to expand it; conversely, 9 (45%) respondents wanted to decrease the hours. Although counselors seemed to spend a considerable amount of time (19%) on activities under the "other" category, the wide range of hours involved (SD = 17.14) and the variety of activities precluded meaningful categorization and summarization.

The average caseload of the rehabilitation counselor was indicated as 72 (Range 250-0; SD = 60). The survey suggested that the ideal caseload the respondents expect is around 64 which is not much different from the overall average of the present caseload, but the variations were wide. Rehabilitation counselors in this survey were responsible chiefly for general rather than specialized caseloads (Table 6).

Specific Findings Related to Research Questions

An analysis was made of Harrison and Zawada's 11 competency categories: (a) Philosophy of Rehabilitation; (b) Human Behavior; (c) Community Resources; (d) Counseling Process; (e) Medical Aspects of Disability; (f) Job Analysis/Placement/Restructuring; (g) Professional Advocacy; (h) Client

Table 6

Type of Rehabilitation Counselor's Caseload

	Caseload Type	N	%
1.	General	22	55
2.	Mental Retardation	4	10
3.	Youth	3	7
4.	Alcohol	1	3
5.	Emotional Disturbance/Mental Health	4	10
6.	Special Education	1	3
7.	Severely Disabled	5	12
	TOTAL	40	100

Assessment; (i) Case Management; (j) Research Utilization; and (k) Management/Supervision of Vocational Rehabilitation Services. The competency categories were derived from a review of the rehabilitation literature and through consultation with rehabilitation counselors and supervisors and administrators with experience as rehabilitation counselors. The 11 areas were used as the basis for the development of a competency-based rehabilitation counselor education program at The University of Michigan. The aim was to determine the relative importance of items in the 11 categories as perceived by experienced counselors. The results were seen as providing the basis for the evaluation, modification, and implementation of curriculum changes in the program.

Each competency category was made up of multiple component items. Each item was measured with 6 Likert-type scales used in a previous research project by Muthard and Salomone (discussion in Chapter II). For example, Counseling Process, one of the competency categories, comprised 11 component items such as, establishing rapport with clients; assisting clients in information searches regarding training and job opportunities; and involving clients' families in the rehabilitation process.

In brief, the competency categories along with their component items were regarded as important for rehabilitation counselors. What was of special interest was the emphasis which rehabilitation personnel placed upon the competencies based on their experience as rehabilitation counselors. An attempt was made to determine if rehabilitation counselors' perceptions of the competencies required on their jobs matched the expectations of educators. The most pertinent results will be presented in tables in the context of each research question. A more complete series of tables are included as appendices.

Research Question 1: To what extent do rehabilitation personnel with experience in rehabilitation counseling agree that the proposed competencies ARE a part of or SHOULD be a part of the job of the rehabilitation counselor?

Scale 1 measures "to what extent is the competency (task) a part of your job?" The scale ranges from 1 (not a part of my job) through 5 (a substantial part of my job) to 8 (a most significant part of my job).

Table 7 reflects those competencies rated as being part of the rehabilitation counselor's job. The higher the mean score the more substantially is the competency considered by the respondent to be required in the rehabilitation counselor's job. Of the 90 competencies in the 11 categories, 63 competencies (70%) received a mean rating of more than 4 (a part of the job). Among them 44 items (50%) received a mean rating of more than 5 (a substantial part of my job). Table 8 reflects those competencies which were rated low. None of the competencies related to Research Utilization and Management and Supervision of Vocational Rehabilitation Services were

Table 7**

Mean Rating of Competencies (tasks) Voted High* by Respondents

Competency Item	N	Mean	SD
A. Philosophy of Rehabilitation			
1.	48	4.48	2.21
2.	48	4.69	2.46
B. Human Behavior			
4.	48	6.25	1.74
5.	48	5.92	1.80
6.	48	5.81	1.79
7.	48	6.44	1.88
8.	48	5.06	2.08
9.	48	5.08	2.16
10.	46	4.91	2.04
11.	47	4.32	2.46
C. Community Resources			
12.	48	4.98	2.38
14.	48	5.31	1.85
15.	47	4.96	2.21
18.	48	5.96	1.91
20.	48	4.73	2.46
24.	48	3.71	2.00
D. Counseling Process			
25.	48	7.21	1.53
26.	48	6.38	2.03
27.	48	6.63	1.88
28.	47	6.45	1.83
29.	47	6.04	1.91
30.	47	5.69	1.71
31.	46	6.35	2.03
32.	47	5.00	2.26
33.	47	5.98	1.88
34.	47	5.70	2.14
35.	48	5.81	2.21
E. Medical Aspects of Disability			
36.	48	6.10	2.00
37.	48	5.23	2.10
38.	48	4.35	2.09
39.	48	5.19	2.12
40.	48	4.13	2.17
F. Job Analysis/Placement/ Restructuring			
41.	48	5.00	2.63
42.	48	5.21	2.05
43.	47	5.21	2.19
44.	48	4.17	2.60
45.	48	5.02	2.88
46.	48	4.63	2.66
47.	47	4.55	2.37
49.	47	5.15	2.38
52.	47	5.96	2.40
53.	47	5.68	2.14
54.	47	5.57	2.15
G. Professional Advocacy			
55.	47	4.62	2.20
57.	47	4.89	2.27
59.	47	4.60	2.28
60.	47	4.64	2.44
63.	47	5.89	2.05
H. Client Assessment			
64.	46	5.70	2.06
65.	47	5.72	1.84
66.	47	4.94	2.23
67.	47	6.55	2.09
68.	47	6.36	1.94
70.	45	4.71	2.49
71.	47	6.02	1.87
I. Case Management			
74.	47	6.30	1.83
75.	47	6.77	1.86
76.	46	5.43	2.43
77.	47	5.78	2.45
78.	47	5.83	2.19
80.	47	5.38	2.26
81.	47	6.64	1.54

*"High" means those tasks which were rated to be "a part of the RC's job" by respondents.
**Please refer to Appendix D for the key to the component items in each competency category.

Table 8**

Mean Ratings of Competencies/Tasks Rated Low* by Rehabilitation Counselors

Competency Number	N	Mean	SD
A. Philosophy of Rehabilitation			
3.	48	3.79	2.60
C. Community Resources			
13.	47	2.98	1.82
16.	47	3.09	2.12
17.	47	2.47	1.93
19.	48	2.65	1.67
21.	47	3.40	2.36
24.	48	3.71	2.00
F. Job Analysis/Placement/Restructuring			
48.	47	3.23	2.40
50.	47	3.74	2.57
51.	47	3.34	2.16
G. Professional Advocacy			
56.	47	3.89	2.30
58.	47	2.36	2.08
61.	47	3.72	2.34
62.	47	3.64	2.45
H. Client Assessment			
69.	47	3.55	2.47
I. Case Management			
72.	47	3.51	2.15
73.	47	3.74	2.37
79.	46	2.61	2.17
J. Research Utilization			
82.	47	3.62	2.12
83.	47	2.87	2.12
84.	46	2.48	1.82
K. Management & Supervision of Vocational Rehabilitation Services			
85.	46	3.41	2.35
86.	46	3.00	2.33
87.	46	2.65	2.26
88.	46	2.74	2.42
89.	46	3.67	2.49
90.	45	2.64	2.22

*"Low" mean-rating tasks were not rated as being "a part of RC's job" by respondents.

**Please refer to Appendix D for the key to the component items in each competency category.

considered to be either a "part" or a "substantial part" of the daily job of rehabilitation counselors.

The differences in the evaluations of rehabilitation counselors and administrators are insignificant. Six of the competencies are statistically significantly different across the two subgroups (Table 9). The most significant difference pertains to aspects of medical consultation in the counseling process which had a mean rating of 4.71 by counselors compared to 5.90 by administrators ($t = -1.82$, $P < .05$). Administrators attached greater importance than counselors to identifying critical issues in medical consultation and in writing consultation requests (competency #39). Administrators tended also to give statistically significantly higher ratings than counselors to the following competencies:

1. Competency #3--explaining the institution of vocational rehabilitation and its organizational structure in relation to social policy, goals, and values; and implementing institutional change at the local, state, and federal level (mean ratings for administrators and counselors, 4.28 and 2.71 respectively ($t = -2.06$, $P < .05$).
2. Competency #85--identifying, assessing, and learning principles and theories involved in program development, organization, and management (mean ratings 4.63 and 2.29 for administrators and counselors respectively ($t = -3.70$, $P < .01$).

Although administrators and counselors differed significantly in their evaluations of the other three competency areas (i.e., competency #17, #79, #87), both groups had relatively low ratings on them.

The relative importance of each of the 11 competency

Table 9

Competencies Considered Significantly Different by Counselors and Administrators as Being a Part of the Rehabilitation Counselor's Job

	Competency	Counselor mean (n=21)	Administrator mean (n=21)	df	t
3.	Explain the instutition of vocational rehabilitation, its organizational structure in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for identifying plans and implementing institutional change at the local, state, and federal level.	2.71	4.28	40	-2.06**
17.	Analyze and restate the community and economic factors which produce organizational change.	1.67	2.80	39	-2.09**
39.	Identify critical issues or points in the counseling process when medical consultation is indicated; know how to write consultation requests to be productive to counseling process.	4.71	5.90	40	-1.82*
79.	Locate and interpret legislation involving legal rights of counselor.	1.95	3.42	38	-2.17**
85.	Identify, assess, and learn principles and theories involved in program development, organization & management.	2.29	4.63	38	-3.70***
87.	Evaluate potential employees' qualifications necessary for counselor recruitment.	2.05	3.21	38	-1.66*

***Significant at .01 level. **Significant at .05 level. *Significant at .10 level.

categories was determined by ascertaining the proportion of the competencies receiving a rating of 5 or more out of the total in each competency category (Table 10). For example, in the competency category, Philosophy of Rehabilitation (A), all of the competencies received a mean rating less than 5, and the category is thus computed as 0 percent; in the competency category, Human Behavior (B), six out of eight competencies received a mean rating above 5, and the category is computed as 75%.

It is clear from Table 10 that Counseling Process (D) is the most important competency area (100%), followed by Human Behavior (B, 75%) and Case Management (I, 70%). Client Assessment (H), Medical Aspects of Disability (E), and Job Analysis/Placement/Restructuring (F) are also important. By contrast, Community Resources (C) and Professional Advocacy (G) are of less concern to counselors in their actual work. As previously indicated, Philosophy of Rehabilitation (A), Research Utilization (J), and Management and Supervision of Vocational Rehabilitation (K) were least important.

Scale 2 measures "to what extent should the competency (task) be a part of your job?" The scale ranges from 1 (not at all) through 4 (about the same as at present) to 6 (much more than at present).

The mean scores regarding the extent to which each competency should be a part of the rehabilitation counselor's job are reflected in Appendix A, Table 1. Of the 90 competencies

Table 10

A Comparison of the Percent of Competencies Receiving a Mean Rating of 5* or Above within Each Category and Rank

	# of items with Average 5* (total items in the category)	% of items with average 5	Rank
A. Philosophy of rehabilitation	0 (3)	0%	8.3
B. Human Behavior	6 (8)	75%	2
C. Community Resources	3 (13)	23%	7
D. Counseling Process	11 (11)	100%	1
E. Medical Aspects of Disability	3 (5)	60%	5
F. Job Analysis/Placement/Restructuring	8 (14)	57%	6
G. Professional Advocacy	1 (19)	11%	8
H. Client Assessment	5 (8)	62%	4
I. Case Management	7 (10)	70%	3
J. Research Utilization	0 (3)	0%	8.3
K. Management/Supervision of Vocational Rehabilitation Services	0 (6)	0%	8.3

*A rating of 5 on scale 1 denotes that a specific competency is considered as a substantial part of the rehabilitation counselor's job.

in the 11 categories, 37 competencies (41%) received a mean rating of less than 4 (about the same as present). That is, respondents felt that 37 competencies should be required less than at present. None of these 37 competencies belong to the following categories: Philosophy of Rehabilitation (A); Human Behavior (B); and Counseling Process (D): respondents indicated that the competencies under these three categories should be maintained at about the same degree as at present. However, all competencies (100%) under the category of Management and Supervision of Vocational Rehabilitation Services (K) and most of the competencies under the categories, Research Utilization (J, 66%); Case Management (I, 60%); Medical Aspects of Disability (E, 60%); and Professional Advocacy (G, 55%), were seen as needing to be performed less than at present. Most of the 90 competencies were rated as needing to be more a part of the job than they are at present (those with a mean rating of 5 or above). Finally, of the 90 competencies, respondents indicated that a majority (59%) should be maintained by rehabilitation counselors about the same as at present, 41% of them should be maintained less than at present, and none should be maintained more than at present.

Differences are minimal between rehabilitation counselors and supervisors/administrators in their assessment of the competencies that should be a part of the rehabilitation counselors' job. Only six are statistically significant across the two sub-groups (Appendix A, Table 2). The most outstanding difference occurred with two competencies in the community resource category (C) that have to do with community and economic factors which influence service delivery (competency #16, #17). Counselors rated both competencies significantly lower than administrators. On competency #16, ($t = -3.16$, $P < .01$), counselors obtained a mean rating of 3.24 compared to 4.45 for administrators clearly suggesting that administrators thought the competencies should be maintained about the same as at present, while counselors felt that they should be required less than at present. On competency #17, ($t = -2.65$, $P < .05$) counselors obtained a mean rating of 2.52 compared to 3.85 for administratos. In this instance, both groups thought that analyzing and restating the community and economic factors which influence the service delivery system should be required less than at present; however, counselors believed this competency should be required much less than supervisors.

The following four competencies were also rated significantly differently by rehabilitation counselors and supervisors:

1. Competency #22--making community resources available for clients' use (mean ratings for administrators and counselors, 4.52 and 3.95, respectively, $t = 2.00$, $P < .05$). Counselors apparently felt that this competency should be required less than at present; however, administrators felt it should be about the same as present.

2. Competency #78--reading and understanding all reports from the total medical allied field (mean ratings for administrators and counselors, 3.75 and 4.57, respectively, $t = 2.51$, $P < .05$). Counselors felt this competency should be maintained at the same level; administrators felt it is less frequently needed.

3. Competency #74--recording counseling and other rehabilitation transactions, giving a description of the rehabilitation process (mean ratings for administrators and counselors, 3.85 and 3.14, respectively, $5 = 2.15$, $P < .05$). Both counselors and administrators thought that this competency should be demonstrated less than at present, counselors indicating that the competency is needed to a lesser extent than administrators.

4. Competency #6--assisting clients in assessing their own behavior (mean ratings for administrators and counselors, 4.00 and 4.48, respectively, $t = 1.69$, $P < .05$). Counselors and administrators agreed that this competency should be required about the same as at present.

Summary

1. Slightly more than two-thirds or 70% of the competencies were rated as being a part of the job of the rehabilitation counselor.
2. Half (50%) were considered to be a substantial part of the rehabilitation counselor's job.
3. Slightly less than one-third, or 30% of the competencies, were not considered to be particularly germane to the functions of rehabilitation counselors, especially management/supervison and research utilization.

Research question #2: What degree of satisfaction is derived from having to demonstrate the competencies with clients?

Scale 3 measured to what extent the rehabilitation counselor found a specific competency satisfying. The scale ranged from 1 (this competency [task] is not part of my job) through 4 (neither satisfying nor dissatisfying) to 6 (very satisfying).

The mean scores for Scale 3, "how satisfying do you find the competency (task)?", are shown in Appendix A, Table 3. Of the 90 competencies in the 11 competency categories, 26 (29%) received a mean rating less than 4 (neither satisfying nor dissatisfying). That is, of 90 competencies, 26 were not satisfying when their use was required. All of the competencies under the category Management and Supervision of Vocational Rehabilitation Services (K) were not considered to be satisfying. Two out of 3 competencies under the category Case Management (I) were also rated not satisfying. Two competencies (#58, increasing fund appropriations for rehabilitation services tc clients, and #86, identifying, describing, and assessing various methods of budget preparation) were found to be "very dissatisfying." Only 4 out of 90 competencies were considered to be satisfying by counselors:

1. Competency #25--establishing rapport with clients, emphasizing them as co-participants in the counseling process
2. Competency #28--assisting clients in vocational and occupational choices as well as in social plans and decision
3. Competency #63--recognizing and describing clients' problems and determining the causes in order to accurately assess ways of handling problems
4. Competency #67--determining the vocational implications based upon assessment, and assisting clients in deciding upon a plan of training and/or employment

Respondents were neutral (neither satisfied or dissatisfied) on about 60 of the competencies (66%).

In comparing counselors and administrators on level of satisfaction with the competencies, a significantly different level of satisfaction was found on 4 competencies (Table 11). Detailed comparison between counselors and supervisors is in Appendix A, Table 2.

Significantly different perceptions were held by counselors and supervisors in regard to analyzing and restating the community and economic factors which influence the service delivery system (competency #17, mean ratings for counselors and administrators, 2.29 and 4.00, respectively, $t = -3.47$, $P < .05$). Counselors found this competency dissatisfying; administrators found it neither satisfying nor dissatisfying.

Summary

1. For the most part, respondents found it neither satisfying nor dissatisfying (neutral) in demonstrating 60 (66%) competencies out of 90.
2. Counselors found it dissatisfying having to demonstrate slightly less than one-third (29%) of the competencies, especially those pertaining to management and supervision; research utilization; case management; and increasing fund appropriations and budget preparation.
3. Satisfaction was expressed in having to manifest only 4 competencies (4%) with clients in relation to establishing rapport with clients with emphasis upon them as co-participants in the counseling process; assisting clients in vocational and occupational choices as well as social and personal plans and decisions; recognizing and describing

Table 11

Competencies Which are Considered Significantly Different by Counselors and Administrators as to Their Satisfaction

Competency	Counselor mean (n=21)	Administrator mean (n=21)	df	t
17. Analyze and restate the community and economic factors which influence the service delivery systems.	2.29	4.00	38	-3.47***
31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.	5.25	4.57	39	-2.44**
61. Identify the current limitations imposed by legislation and the administration.	2.81	4.00	39	-2.41**
69. Increase public awareness and support of the rehabilitation program.	4.38	5.16	38	-1.81*

***Significant at .01 level.
**Significant at .05 level.
*Significant at .10 level.

clients' problems and determining causes in order to accurately assess ways of handling problems; and determining vocational implications based upon assessment.

Research question #3: How frequently do rehabilitation personnel with experience in rehabilitation counseling believe that the competencies are needed with the range of clients in a caseload?

Scale 4 measured "with what proportion of your clients did you (the respondent) demonstrate the competency (task)?" The scale ranged from 1 (with none of my clients) through 4 (with about half of my clients) to 7 (with all of my clients).

The mean rating of respondents on the need for use of competencies with clients appears in Appendix A, Table 4. Of the 90 competencies in the 11 categories, 8 competencies were rated lower than 2 (with very few of my clients). Rehabilitation counselors never or rarely used the 8 competencies with any clients (Table 12). The least used competencies were in 5 categories: Community Resources (C); Professional Advocacy (G); Case Management (I); Research Utilization (J); and Management and Supervision of Vocational Rehabilitation Services (K).

Seventeen competencies (19%) were used by respondents with most of their clients (a mean rating above 5) as noted in Table 13. Examination of these frequently used competencies indicates that they are directly related to the attainment of the client's vocational goal.

Table 12

Competencies Which are Rarely Used with Clients by Rehabilitation Counselors

Competency	N	Mean	SD
C. Community Resources			
17. Analyze and restate community and economic factors which produce organizational change.	46	1.48	1.09
19. Analyze legislation such as the Comprehensive Employment and Training Act, Vocational Education Act, etc., which affects the varying counseling settings.	46	1.90	1.40
G. Professional Advocacy			
58. Increase fund appropriation for rehabilitation services to clients.	45	1.87	1.59
I. Case Management			
79. Locate and interpret legislation involving legal rights of counselors.	45	1.71	1.55
J. Research Utilization			
84. Evaluate proposed research in terms of potential importance of outcomes in order to make decisions regarding participation and support.	45	1.78	1.62
K. Management and Supervision of Vocational Rehabilitation Services			
87. Evaluate potential employees' qualifications necessary for counselor recruitment.	44	1.23	.74
88. Assess counselor skills necessary in preparing periodic staff evaluations.	44	1.30	1.19
90. Investigate various stretegies of organizational change.	43	1.23	.81

Table 13

Competencies Which Are Needed with Most Clients of Rehabilitation Counselors

Competency	N	Mean	SD
B. Human Behavior			
4. Identify and detect those types of interventions which are most likely to reduce physical, emotional, or intellectual barriers to effective functioning in training, work, home and family life.	46	5.39	1.73
5. Identify those clients who need, as well as those who do not need, special services in order to function in training, work, home and family life.	47	5.43	1.57
7. Determine at what point clients are ready to enter training or employment.	45	5.40	1.54
D. Counseling Process			
25. Establish rapport with clients, emphasizing them as co-participants in the counseling process.	45	5.93	1.36
26. Develop agreement with clients regarding the counselor's and client's role in the rehabilitation process.	47	5.45	1.57
28. Assist clients in vocational and occupational choices as well as social and personal plans and decisions.	47	5.04	1.47
31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.	46	5.02	1.63
E. Medical Aspects of Disability			
36. Read and translate medical reports into vocational probabilities (goals, limitations).	46	5.26	1.72
H. Client Assessment			
64. Select appropriate techniques for client assessment.	45	5.07	1.89
67. Determine vocational implications based upon assessment, and assist clients in deciding upon plans of training and/or employment.	46	5.33	1.61
68. Integrate assessment data with information derived by other means so that a description of clients' need may be obtained.	45	5.16	1.52
I. Case Management			
74. Record counseling and other rehabilitation transactions, giving a description of the rehabilitation process.	46	6.30	1.43
75. Maintain confidentiality of case records and materials, being fully aware of confidentiality laws.	46	6.54	1.19
76. Obtain the clients' written agreement regarding the rehabilitation plan.	44	5.70	2.10
77. Inform the clients of their right to appeal and describe to the clients the appeal process.	46	5.30	2.34
78. Read and understand all reports for the total medical allied field.	44	5.30	2.05
81. Monitor client progress toward goals.	46	5.98	1.34

Sixty-five competencies (72%) out of 90 were used with many clients, and eight competencies (10%) were used with few clients.

Summary

1. A substantial portion (82 or 90%) of the competencies were used with many of the rehabilitation clients.
2. A small portion (8 or 10%) of the competencies used by the respondents were in the following categories: Community Resources; Professional Advocacy; Case Management; Research Utilization; and Management and Supervision of Vocational Rehabilitation Services.

Research Question #4: What level of training is perceived as being needed by experienced rehabilitation counselors to achieve proficiency in the competency areas?

Scale 5 measured "what education and training is needed for the satisfactory demonstration/performance of each competency (task)?" Respondents were to assume that the worker had a B.A. but no work experience in rehabilitation or related fields. The scale ranged from 1 (does not apply) through 4 (limited on-the-job training, but several months' experience within the agency) to 7 (M.A. in rehabilitation counseling or related field and on-the-job training).

The mean rating of respondents on necessary education and training is provided in Appendix A, Table 5. Of 90 competencies, only one received a rating less than 4 (limited on-the-job training, but several months' experience within the agency). With the exception of competency #66, (prepare a referral in a narrative form specifying areas to be analyzed and also specifying particular questions to which the psychologist is to respond), respondents indicated that all other (89) competencies required at least some on-the-job training and several months' experience within the agency and education beyond a B.A. degree.

Most competencies (60 or 66%) were rated as requiring fifteen semester hours of graduate study in counseling, testing, occupational information, vocational rehabilitation, or related studies (mean average 5 or above). Competencies which required some graduate training were in the following categories: Human Behavior (B), Counseling Process (D), Medical Aspects of Disability (E), Research Utilization (J), and Management and Supervision of Vocational Rehabilitation Services (K).

Regarding the requirement of an M.A. in rehabilitation counseling or related studies (mean rating of 6 or above), only six of 90 competencies, or 7%, were considered to require the master's degree. Those competencies were:

1. Competency #31--Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities. (mean = 1.15, SD = 1.44)
2. Competency #32--assisting clients in identifying and handling their emotional reactions to the disabilities. (mean = 6.06, SD = 1.71)
3. Competency #33--assisting clients in identifying behavioral changes necessary to achieve their goals (mean = 6.21, SD = 1,32)
4. Competency #34--identifying, examining, using, and

evaluating alternative counseling strategies in assisting clients to achieve goals (mean = 6.47, SD = 1.00)

5. Competency #67--determining vocational implications based upon assessment, and assisting the clients in deciding upon plans of training and/or employment (mean = 6.17, SD = 1.24)

6. Competency #78--reading and understanding all reports from the total allied medical field (mean = 6.20, SD = 1.47)

Summary

1. Rehabilitation counselors felt that graduate study was needed to develop and to demonstrate proficiency in 66% of the competencies, but less than an M.A. degree in rehabilitation counseling was felt to be needed (15 semester hours of graduate study was indicated as essential).
2. A small number (six or 7%) of the competencies were thought to require education at the M.A. degree level in rehabilitation counseling.

Research question #5: To what extent do rehabilitation counselors feel that the competencies are appropriate for other rehabilitation personnel?

Scale 6 measured "who should demonstrate/carry out the competency (task)?" Professional rehabilitation workers in 10 categories included on this scale were (1) counselor; (2) agency supervisor/administrator; (3) placement counselor; (4) social worker; (5) physician; (6) psychiatrist; (7) clinical psychologist; (8) psychometrist; (9) trained clerk; and (10) other (to be specified).

Number of respondents who thought rehabilitation counselors should demonstrate a specific rehabilitation competency is reflected in Appendix A, Table 6. A majority of the respondents (50% or more) thought that 60 (66%) out of 90 competencies should be demonstrated by rehabilitation counselors. The remaining 30 competencies were perceived as being required primarily by the agency supervisor or other helping professionals. Appendix A, Table 6, presents those 30 competencies along with the professionals other than the rehabilitation counselor who should demonstrate the competencies to satisfy rehabilitation functions.

Of the 30 competencies, 25 were considered to be required of the supervisor, four were required of the placement counselor, two were required of the clinical psychologists, and one each was required of the social worker, physician, psychiatrist, and trained clerk.

Summary

1. Although respondents indicated that 66% of the competencies should be demonstrated by rehabilitation counselors, it was felt that supervisors should possess and demonstrate 25, or 28%, of the competencies.
2. Respondents indicated that supervisors should possess competencies related to the following competency categories: Community Resources (C), Philosophy of Rehabilitation (A), Job Analysis/Placement/Restructuring (F), Professional Advocacy (G), Case Management (I), Research Utilization (J), and Management/Supervision of Vocational Rehabilitation Services (K).

CHAPTER V

DISCUSSION

The major topics of discussion include the extent of agreement with the competencies; the extent of disagreement with the competencies; satisfaction with the competencies; utilization of competencies with clients; educational/training requirements; and the appropriateness of the competencies for other rehabilitation professionals. The chapter will conclude with a discussion of the findings in relation to previous theory, research, and practice.

Extent of Agreement with Competencies

Slightly more than two-thirds, 70%, of the competencies were rated as a part of the rehabilitation counselor's job. Half were considered to be a substantial part of the rehabilitation counselor's job. Slightly less than one-third, 30%, of the proposed competencies were not considered to be a part of the rehabilitation counselor's job. The data suggests that the respondents, who all had experience in rehabilitation counseling, are in substantial agreement that most of the competencies are relevant to the functions of rehabilitation.

Substantial agreement exists that the proposed competencies are relevant in the categories: Counseling Process; Case

Management; Human Behavior; Client Assessment; Medical Aspects of Disability; and Job Analysis/Placement/Restructuring.

Extent of Disagreement with Competencies

Experienced rehabilitation counselors felt that less than 30% (or 23 out of 90 competencies) were not especially germane to the work of practicing rehabilitation counselors. Research utilization and management/supervision competencies were consistently perceived as irrelevant to the function of rehabilitation counselors: none of these competencies were rated as "a part" or "substantial part" of the job. Competencies in low demand were in the areas of understanding the philosophy of rehabilitation; research utilization; and management and supervision of vocational rehabilitation services.

An examination of the competencies that received low ratings indicates they require conceptual skills used in program planning, program development, program analysis, and program evaluation. Since these activities are important for maintaining, expanding, and modifying programs to meet client needs, supervisors were perceived as needing these competencies more than counselors. Respondents did not foresee that these competencies will be needed by rehabilitation counselors to any increased extent in the future. To the contrary, reduced requirements were recommended for competencies in research utilization, supervision/management, and to a lesser degree, in case management, medical aspects of disability, and professional advocacy.

Respondents indicated that more than half (59%), of the competencies should be demonstrated "about the same as at the present"; more than one-third, (41%) "less than at present"; and that none of the competencies needed to be demonstrated by the rehabilitation counselor "more than at present."

Satisfaction with Competencies

The amount of satisfaction expressed in having to demonstrate competencies appears, in part, to be a function of whether respondents felt that a demonstration of the competencies was required as part of the rehabilitation counselor's job. For example, research utilization and management and supervision competencies were not viewed as satisfying, which contributed to slightly less than one-third (29%) of the competencies being rated "less than satisfying." For the most part, (66% of the competencies) respondents were neither satisfied nor dissatisfied about having to demonstrate the competencies.

The four competencies (4%) about which obvious satisfaction was expressed clearly relate to skills needed in counselor-client interaction, i.e., counseling process and related activities.

Utilization of Competencies with Clients

The proposed competencies appear to be relevant to the function of rehabilitation counselors since practically all (90%) were used with at least half of all clients. For the small number of competencies (10%) which were used with very few clients, respondents specified that such categories were not a function of the rehabilitation counselor, e.g., Research Utilization and Management and Supervision of Vocational Rehabilitation. These competencies are not likely to be demonstrated in direct client contact.

Education/Training Requirements

Although the participants felt that some graduate education/training was required for the satisfactory achievement and demonstration of the competencies, they also indicated that less than the M.A. degree was required for most. Approximately 15 semester hours of graduate study was seen as sufficient to achieve proficiency in two-thirds, or 66%, of the competencies. The M.A. degree was seen as being required for only six (7%) of the competencies in three categories: Counseling Process; Client Assessment; and Case Management. Less than an M.A. degree was perceived as sufficient to attain proficiency in most of the competencies.

Appropriateness of the Competencies for Other Rehabilitation Professionals

Respondents agreed that two-thirds of the competencies were appropriate for rehabilitation counselors. However, supervisors, rather than counselors, were seen as individuals who should possess competencies in slightly more than one-fourth (28%) of the rehabilitation activities in the following categories: Community Resources; Job Analysis/Placement/Restructuring; Professional Advocacy; and Research Utilization. Further examination seems warranted with regard to expanding the applicability of these competencies for the rehabilitation counselor.

Relationship to Previous Research

Since the respondents in this study were employed chiefly in the state-federal program, their experience is probably similar to that of the respondents in the investigations of Tripp (1975) and Wright and Fraser (1975). Muthard and Salomone's research (1969) and Scorzelli's (1975) included rehabilitation counselors employed in rehabilitation facilities.

Comparisons with other studies are possible for two major activities: counseling and job placement. The participants in this study spent about 22% of their time counseling. This is less than the approximately 34% reported by a national sample of DVR counselors (Muthard & Salomone, 1969), and it is less than the 27% spent by Iowa DVR counselors (Miller, Muthard, & Barillas, 1965). Counselors in the present study spent about three-fourths of their time in activities other than counseling.

About 12% of the counselors' time was spent in job placement--which is 7% more than was reported for a national sample of DVR counselors (Muthard & Salomone, 1969). It is more than 5% reported for Iowa DVR counselors (Miller, Muthard, & Barillas, 1965).

The Michigan Competencies for Rehabilitation Counselors' (Harrison & Zawada, 1975) categories appear to be similar to the task analysis and role and function studies reported in the literature (Muthard and Salomone, 1969; Wright & Fraser, 1975; Scorzelli, 1975; Tripp, 1975). Eleven general competency areas were specified in this study (Table 14) compared

Table 14

Competency and Task Categories of Rehabilitation Counselors Included in Selected Studies

Harrison & Zawada (1975)	Muthard & Salomone (1969)	Wright & Frazer (1975)	Scorzelli (1975)	Tripp (1975)
1. Philosophy of Rehabilitation 2. Human Behavior 3. Community Resources 4. Counseling Process 5. Medical Aspect of disability 6. Job analysis, Job placement & Job Restructuring 7. Professional Advocacy 8. Client Assessment 9. Case Management 10. Research Utilization 11. Management & Supervision of Vocational Rehabilitation Services	1. Counseling 2. Vocational and Social Diagnosis 3. Psychological Testing 4. Providing Occupational Information 5. Arrangement and Coordination of Rehabilitation services 6. Placement and Follow-up 7. Collaboration with Other Rehabilitation Workers.	1. Administration/ Super. 2. Evaluation 3. Consultation 4. Professional and Agency Development 5. Client Counseling and planning 6. Rehabilitation Client Assessment 7. Job Placement 8. Referral and Community Relations 9. Case Management and Special Services 10. Intake and Eligibility Determination *11. Recording and Reporting *12. Incidental Client Assistance and Clerical *Not a category for Personnel possessing the Master's Degree in Rehabilitation Counseling	1. Case Finding 2. Medical Eval./ Referral 3. Psych. Eval./ Referral 4. Client Eligibility 5. Vocational Counsel. 6 Therapeutic Counseling 7. Vocational Eval. 8. Work Adjust. Counseling 9 Group Counseling 10 Training Services 11. Restoration Services 12. Coordination/Case Management 13 Utilization of Community Agencies and Professionals 14. Job Placement 15. Follow-up 16. Supervision Rehab. Personnel	1. General Vocational Rehab. Information 2. Psych. and Counseling Theory 3. Sociological Theory and Problems 4. Medical Aspects of Disability 5. Occupations and the World of Work 6. Research and Stitistics 7. Counseling Skills 8. Test and Measurement Skills 9. Statistics and Research Skill 10. Case Process Management Skill 11. Administration Skills

with a low of eight general categories (Muthard & Salomone, 1969) and high of 16 general categories (Scorzelli, 1975).

The 90 competencies comprising the Michigan Competencies for Rehabilitation Counselors (Harrison & Zawada, 1975) are comparable to the tasks specified by Muthard and Salomone (1969); Tripp (1975); Scorzelli (1975); and Wright and Fraser (1975). Wright and Fraser, who studied counselor tracks, roles, and functions, reported a significantly higher number of tasks probably because their task analysis included the tasks of rehabilitation personnel such as supervisors and rehabilitation paraprofessionals in addition to rehabilitation counselors.

Wright and Fraser identified 145 tasks for which the rehabilitation counselor education master's degree is needed; 63 tasks were identified for which less than the rehabilitation bachelor degree is needed (a period of orientation of several weeks and a minimum of 5 months agency experience). In their study, rehabilitation counselor education determined the amount of education required. Rehabilitation personnel determined the experience requirements.

Competencies in management and the supervision of vocational rehabilitation were not perceived as needed in the daily work of the rehabilitation counselor. These competencies were most likely seen as requiring considerably more experience and education than possessed by the beginning M.A. level rehabilitation counselor (Wright & Fraser, 1975). Excluding the Wright and Fraser tasks, which required post-master's training (administration/supervision 35; evaluation 9; consultation 4; and professional and agency development 2), the remaining 95 tasks tended to approximate closely the original number (90) of the Michigan Competencies for Rehabilitation Counselors which Harrison and Zawada (1975) specified for beginning level M.A. rehabilitation counselors. The finding that competencies in the Research Utilization category were not perceived as a part of the rehabilitation counselor's job is comparable to the outcome of Tripp's research (1975) in which low importance was attached to knowledge in statistics and to research skills.

A rather striking outcome pertains to the level of education needed to develop competencies. The finding that 15 hours of graduate work would be sufficient for most of the competencies is contrary to an earlier suggestion of Dumas, Butler, and Wright (1968) who found support for the M.A. degree in rehabilitation counseling. Conversely, the participants in the present study felt that M.A. level training was needed for only 7% of the competencies (primarily in counseling process and client assessment). Tripp's study again seems closer to the results of this investigation in that his investigation showed that M.A. level training was needed for competencies pertaining to medical aspects of disability, counseling skills, tests and measurements, statistics, and research skills. Since 92% of the participants in this investigation had at least an M.A. degree--although 78% specialized in rehabilitation counseling--the question as to whether an M.A. degree in rehabilitation counseling is really needed deserves serious consideration. The importance of this question is further highlighted when numerous agencies require only the bachelor degree for entry level positions as rehabilitation counselors. State agencies have indicated that on-the-job training and agency experience were adequate preparation (Muthard & Salomone, 1969) for many duties. On the other hand, rehabilitation counselors in facilities have been reported to believe that the M.A. is necessary (Muthard & Salomone, 1969). Somewhat different methods were used by the various researchers in ascertaining this information which may contribute to these differences. Nevertheless, there seem to be different expectations between rehabilitation counselor educators and rehabilitation personnel as to the division of labor and educational requirements in the state-federal rehabilitation program.

CHAPTER VI

SUMMARY

Purpose

This study of rehabilitation counseling competencies was undertaken to assess the relevance of the Michigan Competencies for Rehabilitation Counselors (Harrison & Zawada, 1975) as the basis for a rehabilitation counselor education curriculum to prepare M.A. level rehabilitation counselors. Some of the questions investigated included:

1. To what extent do rehabilitation personnel with experience in rehabilitation counseling agree that the proposed competencies are a part of or should be a part of the rehabilitation counselor's job?
2. What degree of satisfaction is derived from having to demonstrate the competencies with clients?
3. How frequently do rehabilitation personnel with experience in rehabilitation counseling believe that the competencies are needed with the range of clients in a caseload?
4. What level of training is perceived as being needed by experienced rehabilitation counselors to achieve proficiency in the competency areas?
5. To what extent do rehabilitation counselors feel that the competencies are appropriate for other rehabilitation personnel?

The role strain emanating from the discrepancies between the perceived role of the rehabilitation counselors and agency supervisors (Muthard and Salomone, 1959) indicated a need for shared communication to develop a curriculum consistent with competencies required by rehabilitation counselors to produce desired client outcomes. In addition, the Rehabilitation Act of 1973 created an impetus to develop a rehabilitation counseling program relevant to addressing needs of persons with severe disabilities.

Method and Procedures

Participants

The 48 participants (17 females and 31 males) in this study were members of the National Rehabilitation Counseling Association (NRCA). They had at least one year of experience as a rehabilitation counselor. Most were employed in the state-federal vocational rehabilitation program in Michigan. A substantial majority (88%) had earned academic degrees at the M.A. level or above. Rehabilitation counseling was the primary (78%) area of concentration for those with the master's degree.

Procedure

From the Michigan membership list of NRCA, every fourth name was selected and invited to a planning meeting on the competency-based rehabilitation counselor education curriculum. Of 55 persons who were invited, 48 persons participated in the conference. Expenses were reimbursed, and a small honorarium provided,

Instruments

A questionnaire was developed to obtain background and demographic information from the participants. The Rehabilitation Counselor Competency (Task) Inventory (Muthard and Salomone, 1969) was used to assess the Michigan Competencies for Rehabilitation counselors (Harrison & Zawada, 1975). For each of the 90 competencies, the participants were asked to indicate if the competency was a part of the job, the extent to which the competency should be a part of the job, how satisfying was utilizing the competency, with what proportion of clients was the competency used, what preparation was necessary for developing the competency, and who should possess the competency.

Major Findings

1. The participants indicated that most of the competencies (63 out of 90) were relevant to the work of rehabilitation counselors. Slightly more than two-thirds (70%) of the competencies were specified as being a part of the rehabilitation counselor's job and 50% of the competencies were specified as being a substantial part of the job. A high degree of importance was accorded competencies in the following categories: Counseling Process; Client Assessment; Medical Aspects of Disability; Human Behavior; Case Management; and Job Analysis/Placement/Restructuring.
2. Low importance was accorded to competencies in Research Utilization and Management/Supervision since these were not viewed as being a part of the job of the rehabilitation

counselor.

3. Overall, participants expressed neither enthusiasm nor dissatisfaction for the majority of competencies. Satisfaction was expressed for competencies requiring counselor-client interaction, and clear dissatisfaction was expressed toward research utilization and management/supervision competencies.
4. Practically all (90%) of the competencies were used with half or more of the clients.
5. Some graduate study (15 credit hours) was felt to be required to achieve proficiency in two-thirds (66%) of the competencies. Only 6 (7%) of the competencies in the categories of counseling process, clients assessment, and case management were viewed as requiring the M.A. degree.
6. Although most (66%) of the competencies were considered to be relevant to the role and function of the rehabilitation counselors, competencies in categories considered relevant to other rehabilitation specialists involved Community Resources, Job Analysis/Placement/Restructuring, Professional Advocacy, and Research Utilization.

Relationship to Previous Research

The Michigan Competencies for Rehabilitation Counselors contain several components similar to those reported in other studies (Wright & Fraser, 1975; Muthard & Salomone, 1969; Scorzelli, 1975; Tripp, 1975). Like the findings of other studies, participants reported spending more than 75% of their time in activities that require competencies other than counseling.

BIBLIOGRAPHY

American Personnel and Guidance Association. A report of the committee on professional preparation and standards. *Personnel and Guidance Journal*, 1964, *42*, 535-541.

Anthony, W. A., Slowkowski, P., and Bendix, L. Developing the specific skills and knowledge of the rehabilitation counselor. *Rehabilitation Counseling Bulletin*, March 1976, 456-462.

Brammer, L. M., and Springer, H. C. A radical change in counselor education and certification. *Personnel and Guidance Journal*, June 1971, *49* (10), 803-808.

Dumas, N. S., Butler, A. J., Wright, G. N. Counselor perceptions of professional development. Wisconsin Studies in Vocational Rehabilitation Monograph IV. Madison: University of Wisconsin Regional Rehabilitation Research Institute, 1968.

Elfenbein, I. Performance based teacher education: a comparative description. Washington, D. C.: American Association of Colleges for Teacher Education, 1972.

Fine, S. A. Functional job analysis: An approach to a technology for manpower planning. Washington, D. C.: Upjohn Institute, 1973.

Hall, J. H., and Warren, S. H. *Rehabilitation counselor preparation*. Washington: National Rehabilitation Association, National Vocational Guidance Association, 1956.

Harrison, D. K., and Zawada, M. A. *Michigan competencies for rehabilitation counselors*. Ann Arbor, Michigan: The University of Michigan, 1975.

Hattenschwiller, D. Control of the counselor's role. *Journal of Counseling Psychology*, 1970, *17* (5), 436-442.

Joint Liaison Committee of the Council of State Directors of Vocational Rehabilitation and the Rehabilitation Counselor Educators. Guidelines for supervised clinical practice. Washington, D. C.: Vocational Rehabilitation Administration, 1963.

McFarlane, F. R., Hillis, R., Johnson, B. G., and Meadow, L. (Eds.). *Study of the Region IX task force on graduate preparation in rehabilitation counseling*. Washington, D. C.: HEW, RSA, Oct. 1973.

McGowan, J. F., and Porter, T. L. An introduction to the vocational rehabilitation process. Washington, D. C.: Department of Health, Education, and Welfare, Vocational Rehabilitation Administration, 1967.

Miller, L. A., Muthard, J. E., and Barillas, M. A time-study of vocational rehabilitation counselors. Rehabilitation Counseling Bulletin, 1965, 9, 53-60.

Morsh, J. E., Madden. J. M., and Christal, R. E. Job analysis in the United States Air Force. Lackland Air Force Base, Texas: Personnel Research Laboratory, 1961.

Muthard, J. E. and Salomone, P. R. The roles and functions of the rehabilitation counselor. Rehabilitation Counseling Bulletin, Oct. 1969, 13 (1).

National Rehabilitation Counseling Association, Professional Standards Committee. The rehabilitation counselor: What he is and does. Journal of Rehabilitation, 1962, 28 (3), 17.

Randolph, A. Individualized competency-based instruction for rehabilitation education. Dissertation. Morgantown: W. Va. Univ., 1974.

Scorzelli, J. Reactions to program content of a rehabilitation counseling program. Journal of Applied Rehabilitation Counseling, Fall, 1975, 6 (3).

Sinik, D. Rehabilitation counselors on the move. Personnel and Guidance Journal, Nov. 1973, 52 (3), 167-170.

Tripp, J. E. Perceptions of state vocational rehabilitation counselors, supervisors, and administrators of core competencies for professional vocational rehabilitation counseling. Dissertation. Univ. of Northern Colorado, 1975.

Wright, G. N. and Fraser, R. T. Wisconsin studies in vocational rehabilitation: Task analysis for the evaluation, preparation, classification, and utilization of rehabilitation counselor-track personnel. Madison, Wisconsin, Regional Rehabilitation Research Institute, 1975.

Appendix A, Table 1

Mean Rating and Percent of Respondents who Consider the Competency (Task) Should Be a Part of Their Job

Competency	N	Mean	SD	%
A. Philosophy of Rehabilitation				
1. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for developing expectancies.	48	4.27	.89	91.7
2. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for determining goal direction within the confines of existing laws and services.	48	4.23	.97	93.8
3. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for identifying plans and implementing institutional change at the local, state, and federal level.	46	4.30	1.28	89.1
B. Human Behavior				
4. Identify and detect those types of interventions which are most likely to reduce physical, emotional, or intellectual barriers to effective functioning in training, work, home, and family life.	48	4.40	.61	100

Appendix A, Table 1, (continued)

Competency	N	Mean	SD	%
5. Identify those clients who need, as well as those who do not need, special services in order to function in training, work, and home and family life.	48	4.15	.77	93.8
6. Assist clients in assessing their own behavior.	48	4.35	.96	95.8
7. Determine at what point clients are ready to enter training or employment.	48	4.27	.89	93.8
8. Assist clients in understanding stress and in utilizing coping behavior.	48	4.10	1.13	83.3
9. Refine observation skills in studying human behavior.	48	4.08	1.22	81.3
10. Evaluate the choices of goals in studying human behavior.	46	4.33	1.16	84.8
11. Describe and assess counselor feelings toward clients' disabilities, and identify coping behaviors which will allow counselor to assist clients in achieving the highest level of productivity.	47	4.15	1.32	85.1
Community Resources				
12. Identify and locate helpful resources in the community, and incorporate information in manual for referral purposes.	47	4.30	1.25	87.2
13. Identify and restate the goals and services of varying service delivery systems.	47	3.66	1.46	74.5

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
14. Establish inter-intra professional contacts with individuals and agencies to clients.	48	4.58	.74	100
15. Interpret the services and limitations of the varying agencies to clients.	47	4.00	.96	91.5
16. Analyze the community and economic factors which influence the service delivery systems.	47	3.81	1.38	78.7
17. Analyze and restate those factors which produce organizational change.	47	3.25	1.71	61.7
18. Identify and select appropriate educational, occupational, and social information.	48	4.40	.76	93.8
19. Analyze legislation such as the Comprehensive Employment and Training Act, Vocational Education Act etc., which affects the varying counseling settings.	48	3.54	1.57	68.8
20. Evaluate the delivery of services to clients.	47	4.38	1.15	89.4
21. Mobilize the use of resources in a manner that the number of clients needing service is ultimately reduced.	47	3.70	1.80	72.3
22. Make community resources available for clients' use.	48	4.25	.98	93.8
23. Assist clients in making appropriate choice of community resources which will be useful in making decisions.	47	4.13	.92	91.5
24. Specify health professional resources in the region in which disciplines can be responsive to specific functional questions.	48	3.48	1.29	72.9

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
D. Counseling Process				
25. Establish rapport with clients, emphasizing them as co-participants in the counseling process.	48	4.52	.92	97.9
26. Develop agreement with clients regarding the counselor's and client's role in the rehabilitation process.	48	4.29	1.05	93.8
27. Assist clients in examining and evaluating information concerning training and career opportunities.	48	4.48	.97	95.8
28. Assist clients in vocational and occupational choices as well as social and personal plans and decisions.	47	4.30	.86	97.9
29. Assist clients in verbalizing rehabilitation goals.	47	4.28	.99	95.7
30. Involve, when necessary, clients' families and other significant social networks with the rehabilitation process.	47	4.47	1.02	93.6
31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.	47	4.36	1.07	93.6
32. Assist clients in identifying and handling their emotional reactions to the disabilities.	48	4.15	1.17	83.3
33. Assist clients in identifying behavioral changes necessary to achieve their goals.	47	4.32	1.00	91.5

Appendix A. Table 1 (continued)

Competency	N	Mean	SD	%
34. Identify, examine, use and evaluate alternative counseling strategies in assisting clients to achieve goals.	47	4.57	1.06	95.7
35. Assist clients in terminating counseling in a manner that is likely to increase the client's ability to function independently of the counselor.	48	4.42	1.01	95.8
E. Medical Aspects of Disability				
36. Read and translate medical reports into vocational probabilities (goals, limitations).	48	4.21	1.03	91.7
37. Assist clients in understanding, interpreting, and following through on medical consultation, advocating highest treatment.	48	3.94	1.10	85.4
38. Define the goal and function of restorative or assistive devices and their indication in case management.	47	3.91	1.21	85.1
39. Identify critical issues or points in the counseling process when medical consultation is indicated; know how to write consultation requests to be productive to counseling process.	48	4.21	1.09	91.7
40. Enlighten clients to hazards in their life roles involving prevention of illness, accidents, and environmental hazards.	48	3.83	1.15	81.3
F. Job Analysis, Job Placement, and Job Restructuring				
41. Analyze the tasks of a job.	48	4.15	1.49	81.3
42. Analyze the job training and requirements for skills in various jobs.	48	4.44	1.03	89.6

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
43. Assess job requirements and limitations of jobs.	47	4.23	1.09	89.4
44. Recommend restructuring jobs for varying disabilities of clients including elimination of architectural barriers.	46	4.15	1.43	82.6
45. Locate job openings.	48	3.29	1.69	66.7
46. Elicit the cooperation of employers and organized labor in hiring the handicapped.	47	3.89	1.71	74.5
47. Analyze potential difficulties dependent upon hiring the handicapped.	47	3.91	1.41	80.9
48. Identify the manpower problems of specific populations which prevent integration into the labor force.	47	3.53	1.57	70.2
49. Use knowledge of labor market processes to assist clients in the tasks of locating, obtaining, and progressing in employment.	47	4.21	1.23	87.2
50. Analyze methods of employee selection and training.	47	3.70	1.57	72.3
51. Identify the current limitations imposed by legislation and the administration.	47	3.40	1.62	66.0
52. Orient the clients to the world of work and assist them in developing job seeking skills	47	4.42	1.33	89.4
53. Identify, describe, and make available, when necessary, alternative work situations such as sheltered workshops.	47	4.06	1.07	91.5

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
54. Identify educational and training requirements for specific occupations.	47	4.23	.96	93.6
G. Professional Advocacy				
55. Generate cooperation to accept more clients into education, training, and employment.	47	4.38	1.11	91.5
56. Expand medical, social and psychological services to greater numbers of clients.	47	3.72	1.38	76.6
57. Encourage faster medical, social and psychological services to clients.	47	4.17	1.32	83.0
58. Increase fund appropriations for rehabilitation services.	47	2.91	1.83	53.2
59. Increase public awareness and support of the rehabilitation program.	47	4.51	1.23	91.5
60. Generate referrals of disabled people needing rehabilitation.	47	3.64	1.28	78.7
61. Identify and describe differences in services offered by those individuals in the allied health fields in order to generate understanding and cooperation between the varying professions.	47	3.55	1.63	70.2
62. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	47	3.40	1.66	68.1

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
63. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	47	4.32	.89	93.6
H. Client Assessment				
64. Select appropriate techniques for client assessment.	46	4.35	.99	95.7
65. Determine which clients may be more appropriately assessed by other specialities, e.g., psychologists and psychiatrists.	47	4.36	.74	100
66. Prepare a referral in narrative form specifying areas to be analyzed and also specifying particular questions to which the psychologist is to respond.	46	3.96	1.19	89.1
67. Determine vocational implications based upon assessment, and assist the clients in deciding upon plans of training and/or employment.	47	4.13	1.06	91.5
68. Integrate assessment data with information by other means so that a description of clients' need may be obtained.	47	4.21	1.00	93.6
69. Administer and interpret tests to clients and significant others within limit of privacy and ethicality.	47	3.30	1.67	66.0
70. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	45	3.67	1.48	77.8

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
71. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	47	4.36	.99	95.7
I. Case Management				
72. Establish a caseload balance between clients who are severely disabled, moderately disabled, and minimally disabled.	47	3.53	1.65	68.1
73. Determine how financial and other resources will be allocated in provision of client services.	46	3.35	1.64	69.6
74. Record counseling and other rehabilitation transactions, giving a description of the rehabilitation process.	47	3.57	1.12	61.7
75. Maintain confidentiality of case records and materials, being fully aware of confidentiality laws.	47	4.19	.90	95.7
76. Obtain the client's written agreement regarding the rehabilitation plan.	45	3.69	1.40	73.3
77. Inform the clients of their right to appeal, and describe to the clients the appeal process.	47	3.57	1.36	72.3
78. Read and understand all reports from the total medical allied field.	47	4.13	1.17	91.5
79. Locate and interpret legislation involving legal rights of counselors.	46	3.04	1.69	56.5
80. Record factual observations of behaviors attributable to specific disabilities.	47	4.11	.98	91.5

Appendix A, Table 1 (continued)

Competency	N	Mean	SD	%
81. Monitor client progress toward goals.	47	4.04	.83	95.7
J. Research Utilization				
82. Locate, read, and evaluate research reports and construct practice application.	46	4.17	1.29	87.0
83. Identify problems which need research.	46	3.74	1.76	73.9
84. Evaluate proposed research in terms of potential importance of outcome in order to make decisions regarding participation and support.	46	3.59	1.84	69.6
K. Management and Supervision of Vocational Rehabilitation Services				
85. Identify, assess, and learn principles and theories involved in program development, organization, and management.	46	3.80	1.67	76.1
86. Identify, describe, and assess various methods of budget preparation.	46	2.96	1.78	50.0
87. Evaluate potential employees' qualifications necessary for counselor recruitment.	46	3.52	1.87	67.4
88. Assess counselor skills necessary in preparing periodic staff evaluations.	45	3.38	1.98	62.2
89. Determine and monitor appropriate case load.	46	3.78	1.71	76.1
90. Investigate various strategies of organizational change.	45	3.36	1.86	64.4

Appendix A, Table 2

Competencies Which Were Considered Significantly Different by Counselors and Administrators and Should be Part of the Rehabilitation Counselor's Job

	Competencies	Counselor mean (n=21)	Administrator mean (n=21)	df	t
6.	Assist clients in assessing their own behavior	4.48	4.00	40	1.69*
16.	Analyze the community and economic factors which influence the service delivery systems	3.24	4.45	39	-3.16***
17.	Analyze and restate the community and economic factors which influence the service delivery system	2.52	3.85	39	-2.65***
22.	Make community resources available for clients' use	3.95	4.52	40	-2.00**
74.	Record counseling and other rehabilitation transactions, giving a description of the rehabilitation process	3.14	3.85	39	-2.15**
78.	Read and understand all reports from the total medical allied field	4.57	3.75	39	2.51**

***Significant at .01 level
**Significant at .05 level
*Significant at .10 level

Appendix A, Table 3

Percent of Respondents who Found the Rehabilitation Competency (Task) Satisfying

Competencies	N	Mean	SD	%
A. Philosophy of Rehabilitation				
1. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as those determine the parameters of service to clients for developing expectancies.	48	4.13	1.48	54.2
2. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for determining goal direction within the confines of existing laws and services.	48	4.10	1.26	47.9
3. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for identifying plans and implementing institutional change at the local, state, and federal level.	48	4.07	1.61	56.3
B. Human Behavior				
4. Identify and detect those types of interventions which are most likely to reduce physical, emotional, or intellectual barriers to effective functioning in training, work, home, and family life.	48	4.88	.84	89.6
5. Identify those clients who need, as well as those who do not need, special services in order to function in training, work, and home and family life.	45	4.56	1.01	71.1

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
6. Assist clients in assessing their own behavior.	48	4.83	.86	87.5
7. Determine at what point clients are ready to enter training or employment.	47	4.66	.94	76.6
8. Assist clients in understanding stress and in utilizing coping behavior.	48	4.54	1.07	68.8
9. Refine observation skills in studying human behavior.	48	4.35	1.31	52.1
10. Evaluate the choices of goals in studying human behavior.	45	4.53	1.01	66.7
11. Describe and assess counselor feelings toward clients' disabilities, and identify coping behaviors which allow counselors to assist clients in achieving the highest level of productivity.	47	4.02	1.32	48.9
C. Community Resources				
12. Identify and locate helpful resources in the community, and incorporate information in manual for referral purposes.	47	4.30	1.32	51.1
13. Identify and restate the goals and services of varying service delivery systems.	46	3.67	1.63	39.1
14. Establish inter-intra professional contacts with individuals and agencies to clients.	48	4.92	.85	83.3
15. Interpret the services and limitations of the varying agencies to clients.	47	4.21	1.16	44.7
16. Analyze the community and economic factors which influence the service delivery systems.	47	3.83	1.32	36.2

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
17. Analyze and restate those factors which produce organizational change.	46	3.26	1.79	34.8
18. Identify and select appropriate educational, occupational, and social information.	48	4.85	.65	75.0
19. Analyze legislation such as the Comprehensive Employment and Training Act, Vocational Education Act, etc., which affects the varying counseling settings.	47	3.49	1.63	31.9
20. Evaluate the delivery of services to clients.	48	4.08	1.57	60.4
21. Mobilize use of resources in a manner that the number of clients needing service is ultimately reduced.	45	4.53	1.89	44.4
22. Make community resources available for clients' use.	48	4.67	1.23	75.0
23. Assist clients in making appropriate choice of community resources which will be useful in making decisions.	46	4.78	1.15	71.7
24. Specify health professional resources in the region in which disciplines can be responsive to specific functional questions.	47	4.00	1.55	46.8
D. Counseling Process				
25. Establish rapport with clients, emphasizing them as co-participants in the counseling process.	48	5.42	.90	95.8
26. Develop agreement with clients regarding the counselor's and client's role in the rehabilitation process.	46	4.93	1.22	73.9

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
27. Assist clients in examining and evaluating information concerning training and career opportunities.	47	4.94	1.05	80.9
28. Assist clients in vocational and occupational choices as well as social and personal plans and decisions.	47	5.15	.91	89.4
29. Assist clients in verbalizing rehabilitation goals.	47	4.87	1.03	78.7
30. Involve, when necessary, clients' families and other significant social networks with the rehabilitation process.	47	4.83	1.07	78.7
31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.	47	4.85	1.08	76.6
32. Assist clients in identifying and handling their emotional reactions to the disabilities.	48	4.67	1.19	68.8
33. Assist clients in identifying behavioral changes necessary to achieve their goals.	47	4.98	.99	83.0
34. Identify, examine, use, and evaluate alternative counseling strategies in assisting clients to achieve goals.	47	4.85	1.02	74.5
35. Assist clients in terminating counseling in a manner that is likely to increase the client's ability to function independently of the counselor.	48	4.81	1.16	72.9
E. Medical Aspects of Disability				
36. Read and translate medical reports into vocational probabilities (goals, limitations).	48	4.81	1.08	68.8

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
37. Assist clients in understanding, interpreting and following through on medical consultation, advocating highest treatment.	48	4.60	1.20	68.8
38. Define the goal and function of restorative or assistive devices and their indication in case management.	47	4.19	1.38	46.8
39. Identify critical issues or points in the counseling process when medical consultation is indicated; know how to write consultation requests to be productive to counseling process.	48	4.27	1.25	45.8
40. Enlighten clients to hazards in their life roles involving prevention of illness, accidents, and environmental hazards.	48	4.06	1.19	37.5
F. Job Analysis, Job Placement, and Job Restructuring				
41. Analyze the tasks of a job.	48	4.17	1.58	54.2
42. Analyze the job training and requirements for skills in various jobs.	48	4.54	1.17	60.4
43. Assess job requirements and limitations of jobs.	47	4.34	1.15	42.6
44. Recommend restructuring jobs for varying disabilities of clients including elimination of architectural barriers.	47	4.34	1.48	63.8
45. Locate job openings.	47	3.91	1.70	53.2
46. Elicit the cooperation of employers and organized labor in hiring the handicapped.	48	4.02	1.63	50.0

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
47. Analyze potential difficulties dependent upon hiring the handicapped.	47	4.00	1.59	46.8
48. Identify the manpower problems of specific populations which prevent integration into the labor force.	47	3.36	1.76	29.8
49. Use knowledge of labor market processes to assist clients in the tasks of locating, obtaining, and progressing in employment.	47	4.36	1.51	70.2
50. Analyze methods of employee selection and training.	47	3.77	1.63	38.3
51. Identify the current limitations imposed by legislation and the administration.	47	3.51	1.61	29.8
52. Orient the clients to the world of work and assist them in developing job seeking skills.	47	4.79	1.38	80.9
53. Identify, describe, and make available, when necessary, alternative work situations such as sheltered workshops.	47	4.60	1.23	63.8
54. Identify educational and training requirements for specific occupations.	47	4.68	1.07	66.0
G. Professional Advocacy				
55. Generate cooperation to accept more clients into education, training and employment.	46	4.72	1.36	78.3
56. Expand medical, social and psychological services to greater numbers of clients.	46	4.26	1.44	56.5
57. Encourage faster medical, social and psychological services to clients.	46	4.02	1.51	43.5

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
58. Increase fund appropriations for rehabilitation services.	47	2.89	1.88	29.8
59. Increase public awareness and support of the rehabilitation program.	46	4.72	1.34	76.1
60. Generate referrals of disabled people needing rehabilitation.	47	4.09	1.74	55.3
61. Identify and describe differences in services offered by those individuals in the allied health fields in order to generate understanding and cooperation between the varying professions.	47	4.02	1.65	55.3
62. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	47	3.45	1.75	34.0
63. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	47	5.00	.93	80.9
H. Client Assessment				
64. Select appropriate techniques for client assessment.	46	4.76	1.20	73.9
65. Determine which clients may be more approrpiately assessed by other specialities, e.g., psychologists and psychiatrists.	47	4.85	.66	70.2
66. Prepare a referral in narrative form specifying areas to be analyzed and also specifying particular questions to which the psychologist is to respond.	46	4.28	1.36	50.0

Appendix A, Table 3 (continued)

	Competency	N	Mean	SD	%
67.	Determine vocational implications based upon assessment, and assist the clients in deciding upon training and/or employment.	47	5.02	1.21	87.2
68.	Integrate assessment data with information derived by other means so that a description of clients' need may be obtained.	47	4.79	1.18	66.0
69.	Administer and interpret tests to clients and significant others within limit of privacy and ethicality.	47	3.62	1.93	48.9
70.	Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	45	3.73	1.62	33.3
71.	Recognize and describe clients' problems and determine causes in order to accurately assess ways of handling problems.	47	4.89	1.07	76.6
72.	Establish a caseload balance between clients who are severely disabled, moderately disabled, and minimally disabled.	47	3.21	1.67	21.3
73.	Determine how financial and other resources will be allocated in provision of client services.	46	3.41	1.80	30.4
74.	Record counseling and other rehabilitation transactions giving a description of the rehabilitation process.	47	3.94	1.22	31.9
75.	Maintain confidentiality of case records and materials, being fully aware of confidentiality laws.	47	4.23	1.00	34.0
76.	Obtain the client's written agreement regarding the rehabilitation plan.	45	3.89	1.40	33.3

Appendix A, Table 3 (continued)

Competency	N	Mean	SD	%
77. Inform the clients of their right to appeal, and describe to the clients the appeal process.	47	3.53	1.40	19.1
78. Read and understand all reports from the total medical allied field.	47	4.32	1.32	48.9
79. Locate and interpret legislation involving legal rights of counselors.	46	3.07	1.70	19.6
80. Record factual observations of behaviors attributable to specific disabilities.	47	4.34	1.11	38.3
81. Monitor client progress toward goals.	47	4.94	.76	78.7
J. Research Utilization				
82. Locate, read, and evaluate research reports and construct practice application.	46	4.20	1.61	56.5
83. Identify problems which need research.	46	3.35	1.95	37.0
84. Evaluate proposed research in terms of potential importance of outcome in order to make decisions regarding participation and support.	46	3.22	1.90	32.6
K. Management and Supervision of Vocational Rehabilitation Services				
85. Identify, assess, and learn principles and theories involved in program development, organization and management.	46	3.57	1.85	37.0
86. Identify, describe, and assess methods of budget preparation.	46	2.72	1.72	17.4

Appendix A, Table 3 (continued)

	Competency	N	Mean	SD	%
87.	Evaluate potential employees' qualifications necessary for counselor recruitment.	46	3.37	1.99	43.5
88.	Assess counselor skills necessary in preparing periodic staff evaluations.	45	3.04	1.88	33.3
89.	Determine and monitor appropriate case load.	46	3.63	1.77	43.5
90.	Investigate various strategies of organizational change.	45	3.02	1.85	31.1

Appendix A, Table 4

The Mean Rating of the Proportion of Clients with Whom Rehabilitation Counselors Used the Competency

Competency	N	Mean	SD
A. Philosophy of Rehabilitation			
1. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for developing expectancies.	47	4.13	2.15
2. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for determining goal direction within the confines of existing laws and services.	47	4.45	2.21
3. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for identifying plans and implementing institutional change at the local, state, and federal level.	46	2.39	1.79
B. Human Behavior			
4. Identify and detect those types of interventions which are most likely to reduce physical, emotional, or intellectual barriers to effective functioning in training, work, home, and family life.	46	5.39	1.73
5. Identify those clients who need, as well as those who do not need, special services in order to function in training, work, and home and family life.	47	5.43	1.57

Appendix A, Table 4 (continued)

	Competency	N	Mean	SD
6.	Assist clients in assessing their own behavior.	46	4.96	1.69
7.	Determine at what point clients are ready to enter training or employment.	45	5.40	1.54
8.	Assist clients in understanding stress and in utilizing coping behavior.	45	4.07	1.75
9.	Refine observation skills in studying human behavior.	45	4.29	2.00
10.	Evaluate the choices of goals in studying human behavior.	46	4.24	1.96
11.	Describe and assess counselor feelings toward clients' disabilities, and identify coping behaviors which will allow counselor to assist clients in achieving the highest level of productivity.	45	3.0	1.53
C.	Community Resources			
12.	Identify and locate helpful resources in the community, and incorporate information in manual for referral purposes.	47	3.64	2.06
13.	Identify and restate the goals and services of varying service delivery systems.	46	2.76	1.88
14.	Establish inter-intra professional contacts with individuals and agencies to clients.	47	3.57	2.06
15.	Interpret the services and limitations of the varying agencies to clients.	45	4.24	1.63
16.	Analyze the community and economic factors which influence the service delivery systems.	46	2.63	1.85

Appendix A, Table 4 (continued)

Competency	N	Mean	SD
17. Analyze and restate those factors which produce organizational change.	46	1.48	1.09
18. Identify and select appropriate educational, occupational, and social information.	47	4.62	1.68
19. Analyze legislation such as the Comprehensive Employment and Training Act, Vocational Education Act, etc., which affects the varying counseling settings.	46	1.91	1.40
20. Evaluate the delivery of services to clients.	47	4.13	2.33
21. Mobilize use of resources in a manner that the number of clients needing service is ultimately reduced.	45	2.60	1.83
22. Make community resources available for clients' use.	47	4.30	1.82
23. Assist clients in making appropriate choice of community resources which will be useful in making decisions.	46	4.41	1.82
24. Specify health professional resources in the region in which disciplines can be responsive to specific functional questions.	46	3.17	1.82
D. Counseling Process			
25. Establish rapport with clients, emphasizing them as co-participants in the counseling process.	45	5.93	1.36
26. Develop agreement with clients regarding the counselor's and client's role in the rehabilitation process.	47	5.45	1.57
27. Assist clients in examining and evaluating information concerning training and career opportunities.	47	4.98	1.54

Appendix A, Table 4 (continued)

Competency	N	Mean	SD
28. Assist clients in vocational and occupational choices as well as social and personal plans and decisions.	47	5.04	1.47
29. Assist clients in verbalizing rehabilitation goals.	46	4.93	1.56
30. Involve, when necessary, clients' families and other significant social networks with the rehabilitation process.	45	4.24	1.67
31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.	46	5.02	1.63
32. Assist clients in identifying and handling their emotional reactions to the disabilities.	46	3.87	1.78
33. Assist clients in identifying behavioral changes necessary to achieve their goals.	46	4.45	1.60
34. Identify, examine, use, and evaluate alternative counseling strategies in assisting clients to achieve goals.	46	4.24	1.64
35. Assist clients in terminating counseling in a manner that is likely to increase the client's ability to function independently of the counselor.	46	4.39	1.76
E. Medical Aspects of Disability			
36. Read and translate medical reports into vocational probabilities (goals, limitations).	46	5.26	1.72
37. Assist clients in understanding, interpreting, and following through on medical consultation, advocating highest treatment.	46	4.09	1.87
38. Define the goal and function of restorative or assistive devices and their indication in case management.	46	3.15	1.70

Appendix A, Table 4 (continued)

Competency	N	Mean	SD
39. Identify critical issues or points in the counseling process when medical consultation is indicated; know how to write consultation requests to be productive to counseling process.	47	4.34	1.93
40. Enlighten clients to hazards in their life roles involving prevention of illness, accidents, and environmental hazards.	47	3.40	1.80
F. Job Analysis, Job Placement, and Job Restructuring			
41. Analyze the tasks of a job.	47	3.96	2.07
42. Analyze the job training and requirements for skills in various jobs.	47	4.26	1.80
43. Assess job requirements and limitations of jobs.	46	4.13	1.72
44. Recommend restructuring jobs for varying disabilities of clients including elimination of architectural barriers.	47	2.98	1.81
45. Locate job openings.	48	3.54	1.91
46. Elicit the cooperation of employers and organized labor in hiring the handicapped.	47	3.11	1.82
47. Analyze potential difficulties dependent upon hiring the handicapped.	47	3.32	1.98
48. Identify the manpower problems of specific populations which prevent integration into the labor force.	46	2.50	1.93
49. Use knowledge of labor market processes to assist clients in the tasks of locating, obtaining, and progressing in employment.	46	3.85	1.83

Appendix A, Table 4 (continued)

	Competency	N	Mean	SD
50.	Analyze methods of employee selection and training.	46	2.87	1.90
51.	Identify the current limitations imposed by legislation and the administration.	46	2.48	1.91
52.	Orient the clients to the world of work and assist them in developing job seeking skills.	46	4.20	1.85
53.	Identify, describe, and make available, when necessary, alternative work situations such as sheltered workshops.	46	3.74	1.68
54.	Identify educational and training requirements for specific occupations.	46	4.37	1.69
G.	Professional Advocacy			
55.	Generate cooperation to accept more clients into education, training, and employment.	46	3.39	1.81
56.	Expand medical, social and psychological services to greater numbers of clients.	46	3.22	1.85
57.	Encourage faster medical, social and psychological services to clients.	46	3.76	1.86
58.	Increase fund appropriations for rehabilitation services.	45	1.87	1.59
59.	Increase public awareness and support of the rehabilitation program.	45	2.96	2.00
60.	Generate referrals of disabled people needing rehabilitation.	43	3.26	1.89
61.	Identify and describe differences in services offered by those individuals in the allied health fields in order to generate understanding and cooperation between the varying professions.	46	2.50	1.93

Appendix A, Table 4 (continued)

Competency	N	Mean	SD
62. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	45	2.91	2.27
63. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	46	4.93	1.82
H. Client Assessment			
64. Select appropriate techniques for client assessment.	45	5.07	1.89
65. Determine which clients may be more appropriately assessed by other specialities, e.g., psychologists and psychiatrists.	46	4.70	1.63
66. Prepare a referral in narrative form specifying areas to be analyzed and also specifying particular questions to which the psychologist is to respond.	45	3.76	1.64
67. Determine vocational implications based upon assessment, and assist the clients in deciding upon plans of training and/or employment.	46	5.33	1.61
68. Integrate assessment data with information derived by other means so that a description of clients' need may be obtained.	45	5.16	1.52
69. Administer and interpret tests to clients and significant others within limit of privacy and ethicality.	46	3.17	1.94
70. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	44	4.00	2.26
71. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	46	4.91	1.79

Appendix A, Table 4 (continued)

Competency	N	Mean	SD
I. Case Management			
72. Establish a caseload balance between clients who are severely disabled, moderately disabled, and minimally disabled.	45	2.82	2.16
73. Determine how financial and other resources will be allocated in provision of client services.	46	3.50	2.52
74. Record counseling and other rehabilitation transactions, giving a description of the rehabilitation process.	46	6.30	1.43
75. Maintain confidentiality of case records and materials, being fully aware of confidentiality laws.	46	6.54	1.19
76. Obtain the client's written agreement regarding the rehabilitation plan.	44	5.70	2.10
77. Inform the clients of their right to appeal, and describe to the clients the appeal process.	46	5.30	2.34
78. Read and understand all reports from the total medical allied field.	44	5.30	2.05
79. Locate and interpret legislation involving legal rights of counselors.	45	1.71	1.55
80. Record factual observations of behaviors attributable to specific disabilities.	46	4.57	2.00
81. Monitor client progress toward goals.	46	5.98	1.34
J. Research Utilization			
82. Locate, read, and evaluate research reports and construct practice application.	45	2.47	2.00

Appendix A, Table 4 (continued)

	Competency	N	Mean	SD
83.	Identify problems which need research.	45	2.04	1.89
84.	Evaluate proposed research in terms of potential importance of outcome in order to make decisions regarding participation and support.	45	1.78	1.62
K.	Management and Supervision of Vocational Rehabilitation Services			
85.	Identify, assess, and learn principles and theories involved in program development, organization, and management.	45	2.07	2.07
86.	Identify, describe, and assess various methods of budget preparation.	45	2.04	2.11
87.	Evaluate potential employees' qualifications necessary for counselor recruitment.	44	1.23	.74
88.	Assess counselor skills necessary in preparing periodic staff evaluation.	44	1.30	1.19
89.	Determine and monitor appropriate case load.	44	2.18	2.28
90.	Investigate various strategies of organizational change.	43	1.23	.81

Appendix A, Table 5

Education and Training Required for the Satisfactory Demonstration of Certain Competencies

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
A. Philosophy of Rehabilitation					
1. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of services to clients for developing expectancies.	48	4.33	2.00	4.05 (21)	4.57 (21)
2. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of services to clients for determining goal direction within the confines of existing laws and services.	48	4.63	2.04	4.05 (21)	5.00 (21)
3. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of ser-					

Appendix A, Table 5 (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
vice to clients for identifying plans and implementing institutional change at the local, state, and federal level.	48	5.00	2.37	4.62 (21)	5.19 (21)
B. Human Behavior					
4. Identify and detect those types of interventions which are most likely to reduce physical, emotional, or intellectual barriers to effective functioning in training, work, home, and family life.	47	5.53	1.61	5.57 (21)	5.43 (21)
5. Identify those clients who need, as well as those who do not need, special services in order to function in training, work, and home and family life.	48	5.17	1.62	5.05 (21)	5.19 (21)
6. Assist clients in assessing their own behavior.	45	5.60	1.50	5.67 (21)	5.55 (20)
7. Determine at what point clients are ready to enter training or employment.	46	5.43	1.66	5.45 (20)	5.62 (21)
8. Assist clients in understanding stress and in utilizing coping behavior.	47	5.72	1.81	5.20 (20)	5.95 (21)
9. Refine observation skills in studying human behavior.	47	5.26	1.93	5.14 (21)	5.25 (20)

Appendix A, Table 5 (continued)

	Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21
10.	Evaluate the choices of goals in studying human behavior.	46	5.13	2.08	5.30 (20)	4.90 (20)
11.	Describe and assess counselor feelings toward clients' disabilities, and identify coping behaviors which allow counselor to assist clients in achieving the highest level of productivity.	46	5.21	1.87	5.05 (21)	6.00 (19)
C.	Community Resources					
12.	Identify and locate helpful resources in the community, and incorporate information in manual for referral purposes.	48	4.33	1.96	4.38 (21)	4.19 (21)
13.	Identify and restate the goals and services of varying service delivery systems.	46	4.72	2.31	4.15 (20)	4.95 (20)
14.	Establish inter-intra professional contacts with individuals and agencies to clients.	48	4.83	1.86	4.71 (21)	4.81 (21)
15.	Interpret the services and limitations of the varying agencies to clients.	47	4.40	1.75	4.48 (21)	4.25 (20)
16.	Analyze the community and economic factors which influence the service delivery systems.	47	5.04	2.08	4.10 (21)	5.75 (20)

Appendix A, Table 5 (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
17. Analyze and restate those factors which produce organizational change.	47	5.09	2.53	4.24 (21)	5.60 (20)
18. Identify and select appropriate educational, occupational, and social information.	48	5.33	1.60	5.14 (21)	5.19 (21)
19. Analyze legislation such as the Comprehensive Employment and Training Act, Vocational Education Act, etc., which affects the varying counseling settings.	48	4.33	2.38	3.90 (21)	4.71 (21)
20. Evaluate the delivery of services to clients.	48	5.21	2.10	4.86 (21)	5.43 (21)
21. Mobilize use of resources in a manner that the number of clients needing service is ultimately reduced.	46	4.78	2.38	4.14 (21)	5.47 (19)
22. Make community resources available for clients' use.	48	4.75	1.64	4.57 (21)	4.90 (21)
23. Assist clients in making appropriate choice of community resources which will be useful in making decisions.	47	5.04	1.69	4.71 (21)	5.43 (21)
24. Specify health professional resources in the region in which disciplines can be responsive to specific functional questions.	47	4.81	2.18	4.86 (21)	4.70 (20)

Appendix A, Table 5 (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administration (n=21)
D. Counseling Process					
25. Establish rapport with clients, emphasizing them as co-participants in the counseling process.	48	5.40	1.74	5.33 (21)	5.62 (21)
26. Develop agreement with clients regarding the counselor's and client's role in the rehabilitation process.	48	5.21	1.81	5.33 (21)	5.24 (21)
27. Assist clients in examining and evaluating information concerning training and career opportunities.	48	5.54	1.68	5.76 (21)	5.19 (21)
28. Assist clients in vocational and occupational choices as well as social and personal plans and decisions.	47	5.98	1.41	6.10 (20)	5.71 (21)
29. Assist clients in verbalizing rehabilitation goals.	47	5.34	1.77	5.25 (20)	5.38 (21)
30. Involve, when necessary, clients' families and other significant social networks with the rehabilitation process.	46	5.50	1.65	5.60 (20)	5.35 (20)
31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.	46	6.15	1.44	6.40 (20)	5.76 (21)
32. Assist clients in identifying and handling their emotional reactions to their disabilities.	48	6.06	1.71	6.00 (21)	5.95 (21)

Appendix A, Table 5, (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administration (n=21)
33. Assist clients in identifying behavior changes necessary to achieve their goals.	47	6.21	1.32	6.33 (21)	6.05 (20)
34. Identify, examine, use, and evaluate alternative counseling strategies in assisting clients to achieve goals.	47	6.47	1.00	6.38 (21)	6.45 (20)
35. Assist clients in terminating counseling in a manner that is likely to increase the clients' ability to function independently of the counselor.	47	5.91	1.44	5.75 (20)	6.00 (21)
E. Medical Aspects of Disability					
36. Read and translate medical reports into vocational probabilities (goals, limitations).	47	5.98	1.38	5.86 (21)	6.10 (20)
37. Assist clients in understanding, interpreting, and following through on medical consultation, advocating highest treatment.	48	5.63	1.70	5.81 (21)	5.48 (21)
38. Define the goal and function of restorative or assistive devices and their indication in case management.	48	5.42	1.98	5.57 (21)	5.19 (21)
39. Identify critical issues or points in the counseling process when medical consultation is indicated; know how to write consultation requests to be productive to counseling process	48	5.56	1.57	5.57 (21)	5.38 (21)

Appendix A, Table 5 (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
40. Enlighten clients to hazards in their life roles involving prevention of illness, accidents, and environmental hazards.	48	4.67	2.13	4.43 (21)	4.52 (21)
F. Job Analysis, Job Placement, and Job Restructuring					
41. Analyze the tasks of a job.	47	5.00	1.87	4.90 (21)	4.90 (20)
42. Analyze the job training and requirements for skills in various jobs.	48	5.40	1.78	5.24 (21)	5.52 (21)
43. Assess job requirements and limitations of jobs.	47	4.85	1.71	4.81 (21)	4.85 (20)
44. Recommend restructuring jobs for varying disabilities of clients including elimination of architecrual barriers.	48	4.85	2.03	4.48 (21)	5.29 (21)
45. Locate job openings.	47	4.15	1.86	4.00 (21)	4.33 (21)
46. Elicit the cooperation of employers and organized labor in hiring the handicapped.	48	5.10	1.99	5.14 (21)	4.95 (21)
47. Analyze potential difficulties dependent upon hiring the handicapped.	47	5.02	1.91	4.81 (21)	5.20 (20)
48. Identify the manpower problems of specific populations which prevent integration into the labor force.	47	4.53	2.23	4.33 (21)	4.40 (20)

Appendix A, Table 5, (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21
49. Use knowledge of labor market processes to assist clients in the tasks of locating, obtaining, and progressing in employment.	47	5.09	1.84	5.19 (21)	5.10 (20)
50. Analyze methods of employee selection and training.	47	4.85	2.09	4.67 (21)	4.95 (20)
51. Identify the current limitations imposed by legislation and the administration.	47	4.70	2.39	4.52 (21)	4.80 (20)
52. Orient the clients to the world of work and assist them in developing job seeking skills.	47	5.15	1.79	5.10 (21)	4.95 (20)
53. Identify, describe, and make available, when necessary, alternative work situations such as sheltered workshops.	47	5.21	1.77	5.29 (21)	5.15 (20)
54. Identify educational and training requirements for specific occupations.	47	5.64	1.58	5.67 (21)	5.65 (20)
G. Professional Advocacy					
55. Generate cooperation to accept more clients into education, training and employment.	47	5.19	2.11	4.90 (21)	5.50 (20)
56. Expand medical, social and psychological services to greater numbers of clients.	46	5.04	2.19	4.57 (21)	5.63 (19)

Appendix A, Table 5 (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
57. Encourage faster medical, social and psychological services to clients.	47	4.49	2.05	4.43 (21)	4.65 (20)
58. Increase fund appropriations for rehabilitation services.	47	4.62	2.66	4.29 (21)	5.05 (20)
59. Increase public awareness and support of the rehabilitation program.	46	4.76	2.34	4.14 (21)	5.32 (19)
60. Generate referrals of disabled people needing rehabilitation.	47	4.91	2.12	4.62 (21)	5.15 (20)
61. Identify and describe differences in services offered by those individuals in the allied health fields in order to generate understanding and cooperation between the varying professions.	47	4.87	2.19	4.71 (21)	5.00 (20)
62. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	47	5.21	2.31	5.05 (21)	5.45 (20)
63. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	47	5.89	1.58	5.90 (21)	5.95 (20)
H. Client Assessment					
64. Select appropriate techniques for client assessment.	46	5.85	1.56	5.62 (21)	6.20 (20)

Appendix A, Table 5 (continued)

	Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
65.	Determine which clients may be more appropriately assessed by other specialities, e.g., psychologists and psychiatrists.	47	5.91	1.33	5.86 (21)	6.20 (20)
66.	Prepare a referral in narrative form specifying particular questions to which the psychologist is to respond.	45	3.76	1.75	5.33 (21)	5.94 (18)
67.	Determine vocational implications based upon assessment, and assist the clients in deciding upon plans of training and/or employment.	47	6.17	1.24	6.10 (21)	6.40 (20)
68.	Integrate assessment data with information derived by other means so that a description of clients' need may be obtained.	46	5.91	1.33	5.62 (21)	6.11 (19)
69.	Administer and interpret tests to clients and significant others within limit of privacy and ethicality.	46	5.54	2.21	5.05 (21)	5.68 (19)
70.	Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.	45	5.22	2.20	5.29 (21)	4.78 (18)
71.	Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.	47	5.91	1.46	5.48 (21)	6.25 (20)

Appendix A, Table 5 (continued)

	Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
72.	Establish a caseload balance between clients who are severely disabled, moderately disabled, and minimally disabled.	46	4.15	2.48	3.86 (21)	4.63 (19)
73.	Determine how financial and other resources will be allocated in provision of client services.	46	4.63	2.22	4.38 (21)	4.89 (19)
74.	Record counseling and other rehabilitation transactions, giving a description of the rehabilitation process.	47	5.21	1.81	4.76 (21)	5.75 (20)
75.	Maintain confidentiality of case records and materials, being fully aware of confidentiality laws.	47	4.51	2.07	4.24 (21)	4.80 (20)
76.	Obtain the client's written agreement regarding the rehabilitation plan.	45	4.20	2.18	4.15 (20)	4.37 (19)
77.	Inform the clients of their right to appeal, and describe to the clients the appeal process.	46	4.15	2.29	3.95 (21)	4.68 (19)
78.	Read and understand all reports from the total medical allied field.	46	6.02	1.47	6.14 (21)	6.00 (19)
79.	Locate and interpret legislation involving legal rights of counselors.	46	4.09	2.71	3.95 (21)	4.42 (19)
80.	Record factual observations of behaviors attributable to specific disabilities.	47	5.43	1.83	5.52 (21)	5.30 (20)

Appendix A, Table 5 (continued)

Competency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
81. Monitor client progress goals.	46	5.22	1.80	5.19 (21)	5.47 (19)
J. Research Utilization					
82. Locate, read, and evaluate research reports and construct practice application.	46	5.48	2.06	5.05 (21)	5.79 (19)
83. Identify problems which need research.	46	5.41	2.21	5.38 (21)	5.05 (19)
84. Evaluate proposed research in terms of potential importance of outcome in order to make decisions regarding participation and support.	46	5.35	2.40	4.71 (21)	5.58 (19)
K. Management and Supervision of Vocational Rehabilitation Services					
85. Identify assess, and learn principles and theories involved in program development, organization and management.	46	5.72	1.97	5.33 (21)	5.95 (19)
86. Identify, describe, and assess various methods of budget preparation.	46	5.00	2.48	4.48 (21)	5.16 (19)
87. Evaluate potential employees' qualifications necessary for counselor recruitment.	46	5.20	2.36	4.67 (21)	5.42 (19)
88. Assess counselor skills necessary in preparing periodic staff evaluations.	46	5.15	2.42	5.00 (21)	5.11 (19)

Appendix A, Table 5 (continued)

Comptency	N	Mean	SD	Mean Counselor (n=21)	Mean Administrator (n=21)
89. Determine and monitor appropriate case load.	46	5.67	1.94	5.29 (21)	6.21 (19)
90. Investigate various strategies of organizational change.	45	5.77	2.35	5.24 (21)	5.42 (19)

Appendix A, Table 6

Percent of Respondents Who Think the Rehabilitation Counselor
or Other Persons Should be Able to Demonstrate the Competency

Competency	(1) Counselor	(2) Supervisor/ Administrator	(3) Placement Counselor	(4) Social Worker	(5) Physician	(6) Psychiatrist	(7) Clinical Psychologist	(8) Psychometrist	(9) Trained Clerk
A. Philosophy of Rehabilitation									
1.	70%								
2.	46%	52%							
3.	26%	72%							
B. Human Behavior									
4.	80%								
5.	89%								
6.	88%								
7.	80%								
8.	48%			23%		14%	16%		
9.	69%								
10.	71%								
11.	47%	42%							
C. Community Resources									
12.	52%								
13.	34%	58%							
14.	77%								
15.	80%								
16.	31%	58%							
17.	15%	80%							
18.	76%								
19.	24%	76%							
20.	50%								

Appendix A, Table 6 (continued)

Competency	(1) Counselor	(2) Supervisor/ Administrator	(3) Placement Counselor	(4) Social Worker	(5) Physician	(6) Psychiatrist	(7) Clinical Psychologist	(8) Psychometrist	(9) Trained Clerk
21.	32%	57%							
22.	68.9%								
23.	88.6%								
24.	45.5%	25%			20.5%				
D. Counseling Process									
25.	100%								
26.	97.9%								
27.	88.9%								
28.	95.7%								
29.	91.3%								
30.	86.4%								
31.	93.2%								
32.	56.5%								
33.	82.6%								
34.	87.0%								
35.	93.5%								
E. Medical Aspects of Disability									
36.	82.6%								
37.	69.6%								
38.	61.7%								
39.	91.3%								
40.	62.2%								
F. Job Analysis/Placement/Re-Structuring									
41.	59.6%								

Appendix A, Table 6 (continued)

Competency	(1) Counselor	(2) Supervisor/ Administrator	(3) Placement Counselor	(4) Social Worker	(5) Physician	(6) Psychiatrist	(7) Clinical Psychologist	(8) Psychometrist	(9) Trained Clerk
42.	62.2%								
43.	59.1%								
44.	65.2%								
45.	40.9%		52.3%						
46.	45.7%	17.4%	34.8%						
47.	58.7%								
48.	19.6%	37.0%	39.1%						
49.	66.0%								
50.	38.3%	10.6%	44.7%						
51.	32.6%	58.7%							
52.	73.9%								
53.	89.4%								
54.	71.7%								
G. Professional Advocacy									
55.	80.0%								
56.	48.8%	44.0%							
57.	56.8%								
58.	13.3%	82.2%							
59.	53.5%								
60.	63.0%								
61.	48.9%	44.4%							
62.	45.7%	37%							
63.	86.7%								
H. Client Assessment									
64.	88.9%								

Appendix A, Table 6 (continued)

Competency	(1) Counselor	(2) Supervisor/ Administrator	(3) Placement Counselor	(4) Social Worker	(5) Physi-cian	(6) Psychi-atrist	(7) Clinical Psychologist	(8) Psycho-metrist	(9) Trained Clerk
65.	89.4%								
66.	87.0%								
67.	93.6%								
68.	91.1%								
69.	47.8%							30.4%	19.6%
70.	60.0%								
71.	89.4%								
I. **Case Management**									
72.	57.8%								
73.	48.9%	44.4%							
74.	85.1%								
75.	88.6%								
76.	72.7%								
77.	78.3%								
78.	84.1%								
79.	36.4%	50.0%							
80.	84.4%								
81.	90.9%								
J. **Research Utilization**									
82.	58.7%								
83.	48.9%	40.0%							
84.	41.9%	53.5%							

Appendix A, Table 6 (continued)

Competency	(1) Counselor	(2) Supervisor/ Administrator	(3) Placement Counselor	(4) Social Worker	(5) Psysi- cian	(6) Psychi atrist	(7) Clinical Psychologist	(8) Psycho- metrist	(9) Trained Clerk
K. Management/Supervision of Vocational Rehabilitation Services									
85.	35.6%	62.2%							
86.	15.6%	77.8%							
87.	15.6%	77.8%							
88.	17.4%	78.3%							
89.	50.0	47.7%							
90.	18.6%	79.1%							

*Percentages for professionals other than the VR Counselor were included with the counselor less than a 50% rating by respondents

APPENDIX B

THE UNIVERSITY OF MICHIGAN

REHABILITATION COUNSELING SURVEY

A. Personal, Educational, and Employment Information

1. Nature of employment:
   a. Present position: ______________________________
   b. Immediate prior position: ______________________________
2. Age (optional): _____
3. Sex: _____
4. Why were you attracted to Rehabilitation Counseling? ______________
   ____
5. Number of years in Rehabilitation work: _____
6. Present academic level:

	Less than B.A. _____	M.A. _____	Ph.D. _____
	B.A. _____	M.A.+ _____	Ph.D.+ _____
	B.A.+ _____		

7. Field of study and institution:

	Field of study	Institution
B.A. or less	__________	__________
M.A.	__________	__________
Ph.D.	__________	__________

8. Please rate, on the following 5-point scale, how you feel your educational course work prepared you for your position as a rehabilitation counselor.

   Rate your preparation on the following scale:

   1-Superior 2-Very Good 3-Adequate 4-Inadequate 5-Completely Inadequate

Courses					
Rehabilitation Counseling Process	1	2	3	4	5
Philosophy of Rehabilitation	1	2	3	4	5
Psychology of the Disabled	1	2	3	4	5
Placement	1	2	3	4	5
Environmental Information	1	2	3	4	5
Community Resources	1	2	3	4	5
Psychological Assessment	1	2	3	4	5
Medical Information	1	2	3	4	5
Other: __________	1	2	3	4	5
Other: __________	1	2	3	4	5

9. Looking at your education in retrospect, would you have chosen a different area of study?

a. Undergraduate work?_____ If so, what?__________________

b. Graduate work?_____ If so, what?__________________

10. Which courses in your educational program do you feel have been most

a. Beneficial to you in your work as a Rehabilitation Counselor, and why?

______________________________Why?______________________________

______________________________Why?______________________________

______________________________Why?______________________________

______________________________Why?______________________________

______________________________Why?______________________________

B. Least beneficial to you, and why?

______________________________Why?______________________________

______________________________Why?______________________________

______________________________Why?______________________________

______________________________Why?______________________________

11. By percentage, how do you presently distribute your week's work among activities expected by a rehabilitation counselor?

Activity	%
Intake interview	____
Counseling	____
Vocational Job Placement	____
Staff meetings	____
Conferences	____
Report writing	____
Psychological testing	____
Arranging medical, psychological, and training appointments	____
Supervising clients in training	____
Follow-up of clients in job placement	____
Other:	____

12. Would you like to change the way your time is currently distributed?

If so, how?____

____

B. Professional Recommendations

1. If you were given a "free hand" in designing a new educational program in Rehabilitation Counseling, what areas (in order of priority) would you emphasize?

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

2. Given the role of responsibilities of Rehabilitation Counselors, what would you suggest concerning previous experiences of people desiring to enter this profession?

____

____

____

____

____

3. What is your opinion concerning a trial experience in a rehabilitation setting that orients interested persons to the "real world" of rehabilitation before they begin their education program?

____

____

____

____

____

4. What is your opinion concerning Rehabilitation Counselors working with the client throughout the rehabilitation process, from intake through training, placement, and follow-up?

____

____

____

____

____

5a. List any specific areas in Rehabilitation work in which you feel a need for more preparation or training:

______________________ ______________________

______________________ ______________________

______________________ ______________________

5b. What institutions(s), i.e., agency, university, or state or federal rehabilitation program, do you feel is (are) best equipped to provide these needs?

6. Given the new emphasis on services to the severely disabled stated in the Rehabilitation Act of 1973, what do you feel should be most emphasized, in order of priority, in educational programs and in-service training?

7a. To be employed as a Rehabilitation Counselor, one must first pass the State Civil Service examination. Do you consider this to be an adequate determinant of counselor competency?________

b. If not, what suggestions do you have for a more adequate measure?

8a. Do you see job placement as part of your duties as a Rehabilitation Counselor?________Please explain____________________________________

b. How many hours per week do you spend in job placement?____________

c. Do you feel this amount of time is adequate?________If not, why not?

9a. What kind of caseload do you presently have (general, drug, public offender, etc.)?____

b. What is the size of your present caseload?__________

c. Given your present situation, what do you feel to be an ideal caseload?_____ ________________

APPENDIX C

The Competency (Task) Statement and the Six Scales Used by Rehabilitation Counselors

Scale 1. To what extent is the competency (task) a part of your job (consider its significance, relevance, or any other factor you believe to be important).

1 Not a part of my job, does not apply

2 Under unusual circumstances may be a minor part of my job

3

4

5 A substantial part of my job

6

7

8 A most significant part of my job

Scale 2. To what extent should the competency (task) be a part of your job? (Assume that your agency's policies and practices could be modified).

1 Not at all

2 Much less than at present

3 Less than at present

4 About the same as at present

5 More than at present

6 Much more than at present

Scale 3. How satisfying do you find the competency (task)?

1 This competency (task) is not part of my job
2 Very dissatisfying
3 Not satisfying
4 Neither satisfying nor dissatisfying
5 Satisfying
6 Very Satisfying

Scale 4. With what proportion of your clients did you perform the competency (task)?

1 With none of my clients	0%
2 With very few of my clients	1-10%
3 With some of my clients	11-34%
4 With about half of my clients	35-64%
5 With most of my clients	65-89%
6 With nearly all of my clients	90-99%
7 With all of my clients	100%

Scale 5. What education and training is needed for the satisfactory performance of this competency (task)? (Assume that the worker has a B.A. but no work experience in rehabilitation or related fields).

1 Does not apply
2 Little or no training
3 On-the-job training from supervisor, colleagues, and agency consultants
4 Limited on-the-job training, but several months' experience within the agency

5 Fifteen semester hours of graduate study in counseling, testing, occupational information, vocational rehabilitation, or related studies

6 M.A. in rehabilitation counseling or related studies

7 M.A. in rehabilitation or related field and on-the-job training

Scale 6. Who should demonstrate/carry out the competency (task)?

1 Counselor (myself)

2 Agency supervisor or administrator

3 Placement counselor

4 Social worker

5 Physician

6 Psychiatrist

7 Clinical Psychologist

8 Psychometrist

9 Trained clerk

10 Other (counselor aide, case aide, etc.)

APPENDIX D

Rehabilitation Counselor Competencies

A. Philosophy of Rehabilitation

1. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for developing expectancies.

2. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for determining goal direction within the confines of existing laws and services.

3. Explain the institution of vocational rehabilitation, its organizational structures in relation to social policy, political process, historical development, goals, and values as these determine the parameters of service to clients for identifying plans and implementing institutional change at the local, state, and federal level.

B. Human Behavior

4. Identify and detect those types of interventions which are most likely to reduce physical, emotional, or intellectual barriers to effective functioning in training, work, home and family life.

5. Identify those clients who need, as well as those who do not need, special services in order to function in training, work, and home and family life.

6. Assist clients in assessing their own behavior.

7. Determine at what point clients are ready to enter training or employment.

8. Assist clients in understanding stress and in utilizing coping behaviors.

9. Refine observation skills in studying human behavior.

10. Evaluate the choices of goals in studying human behavior.

11. Describe and assess counselor feelings toward clients' disabilities, and identify coping behaviors which will

allow counselors to assist clients in achieving the highest level of productivity.

C. Community Resources

12. Identify and locate helpful resources in the community, and incorporate information in manual for referral purposes.

13. Identify and restate the goals and services of varying service delivery systems.

14. Establish inter-intra professional contacts with individuals and agencies and identify goals.

15. Interpret the services and limitations of the varying agencies to clients.

16. Analyze the community and economic factors which influence the service delivery systems.

17. Analyze and restate those factors which produce organizational change.

18. Identify and select appropriate educational, occupational, and social information.

19. Analyze legislation such as the Comprehensive Employment Act, Vocational Education Act, etc., which affects the varying counseling settings.

20. Evaluate the delivery of services to clients.

21. Mobilize use of resources in a manner that the number of clients needing service is ultimately reduced.

22. Make community resources available for clients' use.

23. Assist clients in making appropriate choice of community resources which will be useful in making decisions.

24. Specify health professional resources in the region in which disciplines can be responsive to specific functional questions.

D. Counseling Process

25. Establish rapport with clients, emphasizing them as co-participants in the counseling process.

26. Develop agreement with clients regarding the counselor's and client's role in the rehabilitation process.

27. Assist clients in examining and evaluating information concerning training and career opportunities.

28. Assist clients in vocational and occupational choices as well as social and personal plans and decisions.

29. Assist clients in verbalizing rehabilitation goals.

30. Involve, when necessary, clients' families and other significant social networks with the rehabilitation process.

31. Discuss with clients the physical, psycho-social, vocational, and educational implications resulting from their disabilities.

32. Assist clients in identifying and handling their emotional reactions to the disabilities.

33. Assist clients in identifying behavioral changes necessary to achieve their goals.

34. Identify, examine, use, and evaluate alternative counseling strategies in assisting clients to achieve goals.

35. Assist clients in terminating counseling in a manner that is likely to increase the clients' ability to function independently of the counselor.

E. Medical Aspects of Disability

36. Read and translate medical reports into vocational probabilities (goals, limitations).

37. Assist clients in understanding, interpreting, and following through on medical consultation, advocating highest treatment.

38. Define the goal and function of restorative or assistive devices and their indication in case management.

39. Identify critical issues or points in the counseling process when medical consultation is indicated; know how to write consultation requests to be productive to counseling process.

40. Enlighten clients to hazards in their life roles involving prevention of illness, accidents, and environmental hazards.

F. Job Analysis, Job Placement, and Job Restructuring

41. Analyze the tasks of a job.

42. Analyze job training and requirements for skills in various jobs.

43. Assess job requirements and limitations of jobs.

44. Recommend restructuring jobs for varying disabilities of clients including elimination of architectural barriers.

45. Locate job openings.

46. Elicit the cooperation of employers and organized labor in hiring the handicapped.

47. Analyze potential difficulties dependent upon hiring the handicapped.

48. Identify manpower problems of specific populations which prevent integration into the labor force.

49. Use knowledge of labor market processes to assist clients in the tasks of locating, obtaining, and progressing in employment.

50. Analyze methods of employee selection and training.

51. Identify the current limitations imposed by legislation and the administration.

52. Orient the clients to the world of work and assist them in developing job seeking skills.

53. Identify, describe, and make available, when necessary, alternative work situations such as sheltered workshops.

54. Identify educational and training requirements for specific occupations.

G. Professional Advocacy

55. Generate cooperation to accept more clients into education, training, and employment.

56. Expand medical, social and psychological services to greater numbers of clients.

57. Encourage faster medical, social and psychological services to clients.

58. Increase fund appropriations for rehabilitation services.

59. Increase public awareness and support of the rehabilitation program.

60. Generate referrals of disabled people needing services.

61. Identify and describe differences in services offered by those individuals in the allied health fields in

order to generate understanding and cooperation between the varying professions.

62. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.

63. Recognize and describe clients' problems and determine causes in order to accurately assess ways of handling problems.

H. Client Assessment

64. Select appropriate techniques for client assessment.

65. Determine which clients may be more appropriately assessed by other specialities, e.g., psychologists and psychiatrists.

66. Prepare a referral in narrative form specifying areas to be analyzed and also specifying particular questions to which the psychologist is to respond.

67. Determine vocational implications based upon assessment, and assist the clients in deciding upon plans of training and/or employment.

68. Integrate assessment data with information derived by other means so that a description of clients' need may be obtained.

69. Administer and interpret tests to clients and significant others within limit of privacy and ethicality.

70. Develop a relevant data base in the realm of physical, psycho-social, vocational, and educational awareness.

71. Recognize and describe clients' problems, and determine causes in order to accurately assess ways of handling problems.

I. Case Management

72. Establish a caseload balance between clients who are severely disabled, moderately disabled, and minimally disabled.

73. Determine how financial and other resources will be allocated in provision of client services.

74. Record counseling and other rehabilitation transactions, giving a description of the rehabilitation process.

75. Maintain confidentiality of case records and materials, being fully aware of confidentiality laws.

76. Obtain the clients' written agreement regarding the rehabilitation plan.

77. Inform the clients of their right to appeal, and describe to the clients the appeal process.

78. Read and understand all reports from the total medical allied field.

79. Locate and interpret legislation involving legal rights of counselors.

80. Record factual observations of behaviors attributable to specific disabilities.

81. Monitor client progress toward goals.

J. Research Utilization

82. Locate, read, and evaluate research reports and construct practice applications.

83. Identify problems which need research.

84. Evaluate proposed research in terms of potential importance of outcomes in order to make decisions regarding participation and support.

K. Management and Supervision of Vocational Rehabilitation Services

85. Identify, assess, and learn principles and theories involved in program development, organization, and management.

86. Identify, describe, and assess various methods of budget preparation.

87. Evaluate potential employees' qualifications necessary for counselor recruitment.

88. Assess counselor skills necessary in preparing periodic staff evaluations.

89. Determine and monitor appropriate case load.

90. Investigate various strategies of organizational change.